Statewide Management Organization Systems Companion Guide

February 2012
Version 1.1

Statewide Management Organization (SMO) Systems Companion Guide

SMO Systems Companion Guide

The Department of Health and Hospitals will provide maintenance of all documentation changes to this Guide using the Change Control Table as shown below.

Change Control Table

Author of Change	Sections Changed	Descriptions	Reason	Date
George Bucher	**Version 1.0**	**Version 1.0**	**Version 1.0**	**2/14/2012**
George Bucher	**Section 2**	**Changes to placement of Magellan ICN** **Removal of allowed amount field in COB**	**Version 1.1**	**2/21/2012**

Statewide Management Organization (SMO) Systems Companion Guide

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Overview

Introduction

DHH is one of the administrative departments within the Executive Branch of State government in Louisiana. The administrative head of DHH is the Secretary, who is appointed by the Governor. The mission of the DHH is to protect and promote health and ensure access to medical, preventive, and rehabilitative services for all citizens of the State of Louisiana (State). DHH is dedicated to fulfilling its mission through direct provision of quality services, development and stimulation of services for others, and utilization of available resources in the most effective manner.

DHH is comprised of the Bureau of Health Services Financing/Medical Vendor Administration (BHSF/MVA), Office of Behavioral Health (OBH), the Office for Citizens with Developmental Disabilities (OCDD), the Office of Aging and Adult Services (OAAS), and the Office of Public Health (OPH). Under the general supervision of the Secretary, these principal offices perform the primary functions and duties assigned to DHH.

DHH, in addition to the program offices, has an administrative office (Office of the Secretary), a financial office (Office of Management and Finance), and various bureaus and boards. The Office of the Secretary is responsible for establishing policy and administering operations, programs, and affairs.

DHH has designated the Office of Behavioral Health (DHH-OBH) as the oversight of the Louisiana Behavioral Health Partnership. The mission of DHH-OBH is to promote recovery and resiliency in the community through services and supports that are preventive, accessible, comprehensive, and dynamic. The former Office of Mental

Health (OMH) and the Office for Addictive Disorders (OAD) have recently been statutorily merged into the DHH-OBH, under the leadership of an Assistant Secretary within DHH. DHH-OBH and BHSF/MVA are collaborating to restructure Medicaid behavioral health services.

DHH-OBH serves adults with a severe mental illness, children and adolescents with a serious emotional/behavioral disorder, and all people experiencing an acute mental illness, as well as individuals of all ages with addictive disorders (AD). DHH-OBH is responsible for planning, developing, operating, and evaluating public mental health (MH) and AD services for the citizens of the State through 10 geographic areas.

DHH-OBH will require the SMO to report encounters for all Medicaid eligible adults. Encounters include all paid services provided to Medicaid enrollees. The SMO will be required to submit encounters to the Fiscal Intermediary (FI) using HIPAA compliant Provider-to-Payer-to-Payer COB 837I (Institutional) and 837P (Professional) transactions.

Encounter Definition

Encounters are records of medically related services rendered by a SMO provider to DHH-OBH Medicaid enrollees enrolled as members with the SMO on the date of service. It includes all services for which the SMO has any financial liability to a provider. An encounter is comprised of the procedures(s) and/or service(s) rendered during the contract. The SMO must report all paid services covered under the SMO Contract. Encounter services include, but are not limited to the following:

- Mental Health Hospital (free standing or distinct part psychiatric unit)
- Mental Health Clinics
- Community Mental Health Centers
- Physicians, Advance Practice Registered Nurses (APRN)
- Licensed Psychologists
- Licensed Clinical Social Workers
- Licensed Professional Counselors
- Licensed Marriage & Family Therapists
- Licensed Addiction Counselors
- Substance abuse and Alcohol Abuse Centers
- Behavioral Health Rehabilitation Agency or Provider
- Psychiatric Residential Treatment Facilities
- Family Support Organizations
- Transition Coordination Agency
- Respite Care Services Agency
- Crisis Receiving Center
- Behavioral Health Rehabilitation Provider Agency

Purpose of Encounter Collection

The purposes of encounter data collection are as follows:

Contract Requirements

The SMO must comply with encounter reporting requirements in accordance with the Contractor's Provider Manual, including payment withhold provisions and penalties for non-reporting, untimely reporting, or inaccurate reporting.

Rate Setting

The Balanced Budget Act of 1997 (BBA) requires the use of base utilization and cost data that is derived from the Medicaid population in order to produce actuarially sound capitation rates. Rates are actuarially sound if they are appropriate for the covered Medicaid population and the services are provided under the Contract. In addition, CMS requires basing rates upon at least one year of recent data that is not more than five years old.

In full consideration of the Contract services rendered by the Contractor, DHH-OBH agrees to pay the Contractor monthly payments based on the number of enrolled Adult Members and other relevant cohort distinctions (age, gender, geographic location, eligibility category, etc.).

Non-Risk reimbursement

Regulations allow PIHPs to receive reimbursement under a non-risk arrangement that differs from the State Plan reimbursement methodology but does not use actuarially sound capitation rates. Paying a PIHP on a non-risk basis will allow the State to pay the entity an administrative, per-member-per-month (PMPM) payment and then reimburse the SMO on an invoice basis pay for services rendered after the services are rendered. The plan may not be at financial risk for changes in utilization or for costs incurred under the contract that do not exceed the non-risk UPL, as defined at §42 CFR 447.362. Comprehensive non-risk contracts are PIHP contracts per §42 CFR 438.2.

The payments under non-risk contracts are not subject to the actuarial soundness requirements that are applied to risk contracts; however, federal financial participation (FFP) for payments under non-risk contracts is subject to a non-risk UPL amount, which is what FFS reimbursement would have paid for the services actually furnished through the PIHP, plus some administrative costs. This option allows the entity and the State to negotiate an alternative reimbursement schedule for payment that is less than or equal to the actual utilization priced at the FFS fee schedule but does not follow the FFS State Plan reimbursement methodology. Invoices not supported by submitted encounter data will not be reimbursed.

Quality Management and Improvement

The SMO program is a Medicaid program partially funded by CMS. The SMO is required to collect and report performance measures (PM) data that demonstrates adherence to clinical practice and/or improvement in patient outcomes. Measures as defined by DHH-OBH, include Health Care Effectiveness Data and Information Set (HEDIS) measures, Agency for Healthcare Research and Quality (AHRQ) measures and/or other measures as determined by DHH-OBH as outlined in the contract. DHH-OBH will use encounter data to evaluate the performance of the SMO and to audit the validity and accuracy of the reported measures.

Continuous Quality Improvement Plan for Oversight and Assessment of Medicaid Coordinated Care

According to the BBA, a written quality strategy plan is required to serve as the guiding principles for assessing the quality, effectiveness, and efficiency of services rendered to Medicaid enrollees. The goal of the quality strategy plan is to purchase the best value health care and services for DHH beneficiaries, to improve access to services for underserved and vulnerable beneficiary populations, and to protect them from substandard care. The objectives of the plan are to assess, monitor, and measure the improvement in health care and behavioral health services provided directly or through referrals to Medicaid SMO beneficiaries, and to ensure the accuracy in claim payments for services rendered.

Continuous quality improvement focuses on measuring and improving the quality of the encounter data available to DHH-OBH. Data from the SMO will continue to undergo data quality checks beyond the minimum criteria used in the edit process. The results of both the encounter edit codes and ongoing data quality monitoring are combined to develop plan-specific Quality Strategic Opportunity Plans (encounter quality improvement plans).

Implementation Date

Within sixty (60) days of operation in the applicable geographic service area (GSA), the SMO's Systems shall be ready to submit encounter data to DHH's FI in a HIPAA compliant provider-to-payer-to-payer COB format.

DHH-OBH Responsibilities

DHH-OBH is responsible for administering the Louisiana Behavioral Health Partnership Program. Administration includes data analysis, production of feedback and comparative reports to the SMO, data confidentiality, and the contents of this SMO Systems Companion Guide. Written questions or inquiries about the Guide must be directed to:

Name: Randall L. Lemoine	**Name:** Amanda Joyner

Name: Randall L. Lemoine	**Name:** Amanda Joyner
Telephone: 225-242-8670	**Telephone:** 225-342-7141
Fax: 225-342-1984	**Fax:** 225-342-8687
E-mail: randall.lemoine@la.gov	**Email:** amanda.joyner2@la.gov

DHH-OBH is responsible for the oversight of the Contract and SMO activities. DHH-OBH's claim responsibilities include production and dissemination of the Systems Companion Guide, the initiation and ongoing discussion of data quality improvement with the SMO, and SMO training. DHH-OBH will update the Systems Companion Guide on a periodic basis.

Fiscal Intermediary (FI) Responsibilities

Molina is under contract with DHH to provide Louisiana Medicaid Management Information System (LMMIS) services including the acceptance of electronic claim reporting from the SMO. DHH's FI will be responsible for accepting, editing and storing SMO 837 claims data. The FI will also provide technical assistance to the SMO during the 837 testing process.

The Contractor will receive a roster (834 X12) listing Medicaid eligible adults at the beginning of each month and daily files for updates. The Contactor will also receive a capitation payment at the beginning of each month for each Medicaid eligible adult that is not retroactively or spend-down eligible. Actuarially sound capitation rate ranges for the T-XIX Members shall be set by DHH's actuarial Contractor, using the methodology described in the Overview of Rate Setting Methodology contained in the Procurement Library.

X12 Reporting

If the file contains syntactical errors, the segments and elements where the error occurred are reported in a 997 Functional Acknowledgement. The TA1 report is used to report receipt of individual interchange envelopes that contain corrupt data or an invalid trading partner relationship.

After claim adjudication, an ANSI ASC X12N 835 Remittance Advice (835) will be delivered to the SMO if requested by the SMO. The SMO must prearrange for receipt of 835 transactions.

Proprietary Reports

The FI will also provide the SMO with a monthly financial reconciliation report. The file layout can be found in Appendix D of this Guide.

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Statewide Management Organization (SMO) Responsibilities

It is the SMO's responsibility to ensure accurate and complete encounter reporting from their providers.

The SMO must evaluate the adequacy of, and revise if necessary, the data collection instruments and processes being used by its providers. With regard to provider identification, the SMO is responsible for ensuring that the appropriate NPI, taxonomy and 9-digit zip code are submitted in each transaction.

The SMO is expected to investigate the findings of encounter denials and be prepared to explain the underlying reasons for the identified data quality issue(s). As data issues are discussed, the SMO must incorporate corrective action steps into the encounter quality improvement plan. Any issues that are not fully addressed on a timely basis may be escalated into a corrective action plan (CAP). The CAP will include a listing of issues, responsible parties, and projected resolution dates

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Transaction Set Supplemental Instructions

Introduction

The HIPAA transaction and code set regulation requires that covered entities exchanging specified transactions electronically must do so using the appropriate ANSI ASC X12 EDI formats. Further, HIPAA has defined how each of these transactions is to be implemented. Implementation instructions are contained in detailed instruction manuals known as implementation guides (IGs). The IGs provide specific instructions on how each loop, segment, and data element in the specified transaction set is used.

The 837 formats used for DHH-OBH are the 837 Institutional and 837 Professional Provider-to-Payer-to-Payer Coordination of Benefits (COB) Model, as defined in the HIPAA IGs.

This Guide will not provide detailed instructions on how to map encounters from the SMO's' systems to the 837 transactions. The 837 IGs contain most of the information needed by the SMO to complete this mapping.

The SMO shall create their 837 transactions for DHH using the HIPAA IG for Version 5010. On January 16, 2009, HHS published final rules to adopt updated HIPAA standards; these rules are available at the Federal Register.

In one rule, HHS is adopting X12 Version 5010 for HIPAA transactions. For Version 5010, the compliance date for all covered entities is January 1, 2012.

The ANSI ASC X12N 837 (Healthcare Claim Transactions – Institutional, Professional, and Dental) Companion Guide is intended for trading partner use in conjunction with the ANSI ASC X12N National Implementation Guide. The ANSI ASC X12N Implementation Guides can be accessed at http://www.wpc-edi.com/content.

Molina Companion Guides and Billing Instructions

Molina, as DHH's FI, provides Electronic Data Interchange (EDI) services. The EDI validates submission of ANSI X12 format(s). If the file contains syntactical error(s), the segments and elements where the error(s) occurred are reported in a 997 Functional Acknowledgement. The TA1 report is used to report receipt of individual interchange envelopes that contain corrupt data or an invalid trading partner relationship. The FI HIPAA Companion Guides can be found at www.lamedicaid.com or www.lmmis.com. Select HIPAA Billing Instructions and Companion Guides from the left hand menu.

DHH Supplemental Instructions

DHH requires the SMO to submit the Provider-to-Payer-to-Payer COB Model of the 837. There can be multiple COB loops. The loops in the 837 HIPAA implementations that are used to convey information regarding adjudication are the 2320 (Other Subscriber Information), 2430 (Service Line Adjudication Information) and 2330B (Other Payer information). In the first COB loop, the SMO will be required to include information about the SMO provider claim adjudication. In the first loop, the SMO shall place their unique DHH carrier code in loop 2300B, NM109. In subsequent loops, the SMO shall provide DHH with any third-party payments. In these loops, the SMO must include the DHH carrier code of the other payer. There can be only one single subsequent loop per unique payer.

SMO Carrier Code Assignment

Plan Name: Magellan SMO Assigned Carrier Code: 999996

Batch Submissions

The SMO may submit batch encounters, up to 99 files per day. Batch encounters maximum recommended file size is 25 MB.

Accepting and Storing Encounters

DHH's FI will be responsible for accepting, editing and storing SMO 837 encounter data. The FI will also provide technical assistance to the SMO during the 837 testing process.

SMO Internal Control Number (ICN)

The SMO ICN is to be populated in Patient Control Number, Loop 2300, CLM01. The number that the SMO transmits in this position is echoed back to the submitter in the

835 and other transactions. This permits the SMO to use the value in this field as a key in the SMO's system to match the encounter to the information returned in the 835 transaction.

Financial Fields

The financial fields that DHH requests the SMO to report include:

- Header and Line Item Submitted Charge Amount
- Header and Line Item Approved (Allowed) Amount
- Header and Line Item SMO Paid Amount
- Header and Line Item Adjustment Amount

Header and Line Item Submitted Charge Amount — The SMO shall report the provider's charge or billed amount. The value may be "$0.00" if the SMO contract with the provider is capitated and the SMO permits zero as a charged amount. If the submitted charge is billed as "$0.00", the MMIS will calculate the paid amount as zero since DHH pays the lesser of the submitted charge or the calculated fee amount. A value other than "$0.00" must be submitted when the provider bills on a FFS basis.

Header and Line Item SMO Paid Amount — If the SMO paid the provider for the service, the Paid Amount shall reflect the amount paid. If the service was not covered by the SMO or was covered under a subcapitation arrangement, "$0.00" is the appropriate Paid Amount. This amount is stored in the encounter as a Third Party Liability (TPL) amount.

Header and Line Item Adjustment Amount — If the Paid Amount reflects any adjustments to the Submitted Line Item Charge Amount, the adjustment amounts must be reported. Any time the charge amount does not equal the paid amount, the SMO is required to report both the Adjustment Amount and the adjustment reason code. The adjustment amounts and reason codes are critical to the correct pricing of the encounter in the MMIS.

Professional Identifiers

The SMO is required to submit the provider's NPI, Taxonomy Code and 9-digit zip code in each encounter.

Supplementation of CMS-1500 and UB-04

Certain information may be required that is not routinely present on the UB-04 or CMS-1500. In these circumstances, the SMO must obtain valid medical records to supplement the UB-04 or use logic from the paper claim to derive the required additional information for the 837 transactions.

Spend Down

As providers deliver services during the period prior to the individual meeting the spend-down requirement (or not knowing where the spending is within the limit), they complete the Provider Request Form to submit information to MEDS regarding the applicable cost of services provided.

When MEDS determines the individual has hit the spend-down amount and qualifies for Medicaid coverage, MEDS completes the 110 MNP and sends the 110 MNP back to all applicable providers. The MNP is applicable for a single day only, and tells the provider(s) how much the individual is responsible for and how much Medicaid will pay. The provider must then bill the claim to Medicaid with the attached MNP for Medicaid to pay. This is the step the SMO will have to incorporate in order to receive these partial claims and 110 MNPs from providers.

Since the 110 MNP is applicable for only a single day, not all services prior to that date are covered by Medicaid, and all services after that day are covered based upon MEDS forwarding type case 21 to Molina to indicate Medicaid eligibility. Molina will then forward the beginning and ending dates of coverage to the SMO on the 834.

Providers will have to be informed to submit their appropriate claims to the SMO with the 110 MNP for the date the individual meets their spend down requirement. The SMO should know all services after that date (and through the end of the approved three-month period) are covered based upon the eligibility span in the 834 sent to the SMO from Molina.

The SMO will pay the Medically Needy claims (on and after the approved spend-down date) and then invoice the state in a similar fashion as it does for children's services.

Category II CPT Codes

DHH requires the use of applicable Category II CPT Codes or HCPCS Level II G Codes for performance measurement. These codes will facilitate data collection about the quality of care rendered by coding certain services and test results that support nationally established performance measures. In conjunction with the Category II CPT Codes, the PQRI quality-data codes (QDCs) follow current rules for reporting other CPT and HCPCS codes.

On the ASC X12N 837 professional health care claim transaction, Category II CPT and HCPCS Level II codes are submitted in the SV1 "Professional Service" Segment of the 2400 "Service Line" Loop. The data element for the procedure code is SV101-2 "Product/Service ID." Note that it is also necessary to identify in this segment that you are supplying a Category II CPT/HCPCS Level II G-code by submitting the "HC" code for

data element SV101-1. Necessary data elements (or fields) include, but are not necessarily limited to, the following:

- Date of service;
- Place of service;
- PQRI QDC(s), along with modifier (if appropriate);
- Diagnosis pointer;
- Submitted charge ($0.00 shall be entered for PQRI codes);
- Rendering provider number (NPI).

The submitted charge field cannot be left blank. The amount of $0.00 shall be entered on the claim as the charge.

Transaction Type

The following tables provide guidance on the use of 837s. This guidance is subject to change. **Please note that the following tables contain all DHH provider types, including new provider types specific to SMO operations and are outlined consistent with the services manual included in the SMO contract.**

At present, the following provider types use 837I:

Provider Type	Description
44	Home Health Agency
54	Ambulatory Surgical Center
55	Emergency Access Hospital
59	Neurological Rehabilitation Unit (Hospital)
60	Hospital
64	Mental Health Hospital (Free-Standing)
65	Rehabilitation Center
69	Hospital – Distinct Part Psychiatric Unit
76	Hemodialysis Center
77	Mental Health Rehabilitation
80	Nursing Facility

The following provider types use 837P.

Provider Type	Description
01	Fiscal Agent - Waiver
02	Transitional Support - Waiver
03	Children's Choice - Waiver (in-state only)
04	Pediatric Day Health Care (PDHC) facility
06	NOW Professional (Registered Dietician, Psychologist, Social Worker)
07	Case Mgmt - Infants & Toddlers (in-state only)
08	Case Mgmt - Elderly (in-state only)
09	Hospice Services (in-state only)
10	Comprehensive Community Support Services
11	Shared Living - Waiver (in-state only)
12	Multi-Systemic Therapy (in-state only)
13	Pre-Vocational Habilitation (in-state only)
14	Adult Day Habilitation - Waiver (in-state only)
15	Environmental Accessibility Adaptation - Waiver (in-state only)
16	Personal Emergency Response Systems - Waiver
17	Assistive Devices - Waiver
18	Community Mental Health Center (in-state only)
19	Doctor of Osteopathy (DO) and Doctors of Osteopathy(DO) Group
20	Physician (MD) and Physician (MD) Group
21	EDI Billing Agent
22	Waiver Personal Care Attendant
23	Independent Lab
24	Personal Care Services (LTC/PCS/PAS) (in-state only)
25	Mobile X-Ray/Radiation Therapy Center
26	Pharmacy (out-of-state for crossovers

Provider Type	Description
	only)
27	Dentist and Dental Group
28	Optometrist and Optometrist Group
29	EarlySteps and EarlySteps Group (in-state only)
30	Chiropractor and Chiropractor Group
31	Medical or Licensed Psychologist
32	Podiatrist and Podiatrist Group
33	Prescribing Only Provider
34	Audiologist
35	Physical Therapist
36	Not assigned
37	Occupational Therapist
38	School-Based Health Center (in-state only)
39	Speech/Language Therapist
40	DME Provider (out-of-state for crossovers only)
41	Registered Dietician
42	Non-Emergency Medical Transportation (in-state only)
43	Case Mgmt - Nurse Home Visit - 1st Time Mother (in-state only)
44	Home Health Agency (in-state only)
45	Case Mgmt - Contractor (in-state only)
46	Case Mgmt - HIV (in-state only)
47	Case Mgmt - CMI
48	Case Mgmt - Pregnant Woman
49	Case Mgmt - DD
50	PACE Provider
51	Ambulance Transportation
53	Direct Care Worker
54	Ambulatory Surgical Center (in-state only)

Provider Type	Description
55	Emergency Access Hospital
57	Not in Use: to-be used for RN
58	Not in Use: to-be used for LPN
59	Neurological Rehabilitation Unit (Hosp)
60	Hospital
61	Venereal Disease Clinic
62	Tuberculosis Clinic
63	Tuberculosis Inpatient Hospital
66	KIDMED Screening Clinic (in-state only)
67	Prenatal Health Care Clinic
68	Substance Abuse and Alcohol Abuse Center
70	LEA and School Board (EPSDT Health Services) (in-state only)
71	Family Planning Clinic
72	Federally Qualified Health Center (in-state only)
73	Licensed Clinical Social Worker (LCSW)
74	Mental Health Clinic
75	Optical Supplier (in-state only)
76	Hemodialysis Center (in-state only)
77	Mental Health Rehabilitation (in-state only)
78	Nurse Practitioner and Nurse Practitioner Group
79	Rural Health Clinic (Provider Based) (in-state only)
80	Nursing Facility (in-state only)
81	Case Mgmt - Ventilator Assisted Care Program
82	Personal Care Attendant - Waiver (in-state only)
83	Respite Care (Center Based)- Waiver (in-state only)
84	Substitute Family Care - Waiver (in-state only)

Provider Type	Description
85	ADHC Home and Community Based Services - Waiver (in-state only)
86	ICF/DD Rehabilitation
87	Rural Health Clinic (Independent) (in-state only)
88	ICF/DD - Group Home (in-state only)
89	Supervised Independent Living - Waiver (in-state only)
90	Nurse-Midwife
91	CRNA or CRNA Group
92	Private Duty Nurse
93	Clinical Nurse Specialist
94	Physician Assistant
95	American Indian / Native Alaskan "638" Facilities
96	Psychiatric Residential Treatment Facility
97	Adult Residential Care
98	Supported Employment - Waiver (in-state only)
99	Greater New Orleans Community Health Connection (in-state only)
AA	Assertive Community Treatment Team (ACT)
AB	Prepaid Inpatient Health Plan (PIHP)
AC	Family Support Organization
AD	Transition Coordination (Skills Building)
AE	Respite Care Service Agency
AF	Crisis Receiving Center
AG	Behavioral Health Rehabilitation Provider Agency
AH	Licensed Marriage & Family Therapist (LMFT)
AJ	Licensed Addiction Counselors (LAC)
AK	Licensed Professional Counselors (LPC).
AL	Community Choices Waiver Nursing

Provider Type	Description
AM	Home Delivered Meals
AN	Caregiver Temporary Support

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Repairable Denial Edit Codes and Descriptions

Introduction

DHH has modified edits for encounter processing. In order to ensure DHH has the most complete data for rate setting and data analysis, the SMO is to repair as many edit codes as possible. The table below represents the edit codes that may be corrected by the SMO.

EDIT CODE	EDIT DISPOSITION – DENY (REPAIRABLE OR REPAIRABLE UNDER LIMITED CIRCUMSTANCES)[1] EDIT DESCRIPTION
003	INVALID RECIPIENT NUMBER
005	INVALID STATEMENT FROM DATE
006	INVALID STATMENT THRU DATE
007	SERVICE THRU DATE LESS THAN SERVICE FROM DATE
008	SERVICE FROM DATE LATER THAN DATE PROCESSED
009	SERVICE THRU DATE GREATER THAN DATE OF ENTRY
012	ORIGINAL CLAIM WITH AN ADJUSTMENT OR VOID REASON CODE
013	ORIGINAL CLAIM WITH AN ADJUSTMENT OR VOID ICN
015	ACCIDENT INDICATOR MUST BE Y N SPACE
016	ACCIDENT INDICATOR NOT Y N OR SPACE

[1] These denials may be corrected or corrected only in some instances

EDIT CODE	EDIT DISPOSITION – DENY (REPAIRABLE OR REPAIRABLE UNDER LIMITED CIRCUMSTANCES)[1] EDIT DESCRIPTION
017	EPSDT INDICATOR NOT Y N OR SPACE
020	INVALID OR MISSING DIAGNOSIS CODE
022	INVALID BILLED CHARGES
023	RECIPIENT NAME IS MISSING
024	BILLING PROVIDER NUMBER NOT NUMERIC
026	TOTAL DOCUMENT CHARGE MISSING OR NOT NUMERIC
028	INVALID MISSING PROCEDURE CODE
040	ADMISSION DATE MISSING OR INVALID
041	ADMISSION DATE GREATER THAN SERVICE FROM DATE
042	INVALID UB92, ETC TYPE BILL CODE
043	INVALID ATTENDING PHYSICIAN
044	NATURE OF ADMISSION MISSING OR INVALID
045	PATIENT STATUS CODE INVALID OR MISSING
046	PATIENT STATUS DATE MISSING OR INVALID
047	PATIENT STATUS DATE GREATER THAN THRU DATE
048	INVALID OR MISSING PROCEDURE CODE
049	INVALID/CONFLICT SURGICAL DATE
055	ACCOMMODATION/ANCILLARY CHARGE MISSING OR INVALID
060	COVERED HOSPITAL DAYS NOT NUMERIC OR MISSING
063	THE TOTAL HOSPITAL CHARGE IS NOT NUMERIC
064	THE NET BILLED AMOUNT IS NOT NUMERIC
065	THE SIGNATURE INDICATOR MUST BE Y, N, OR BLANK
068	INVALID SOURCE OF ADMISSION
069	INVALID OCCURRENCE DATE
071	STATEMENT COVERS FROM DATE INVALID
072	STATEMENT COVERS THRU DATE INVALID
073	STATEMENT COVERS FROM DATE LESS THAN SERVICE FROM DATE
074	STATEMENT COVERS THRU DATE IS GREATER THAN SERVICE THRU
081	INVALID OR MISSING PATIENT STATUS DATE
082	INVALID PATIENT STATUS CODE
085	INVALID OR MISSING UNITS VISITS AND STUDIES

EDIT CODE	EDIT DISPOSITION – DENY (REPAIRABLE OR REPAIRABLE UNDER LIMITED CIRCUMSTANCES)[1] EDIT DESCRIPTION
092	INVALID PROCEDURE MODIFIER (INVALID OR MISSING MODIFIER)
093	REVENUE CODE MISSING/INVALID
095	CONDITION CODE 40 FROM THROUGH NOT EQUAL
096	REVENUE CHARGE MISSING OR INVALID
097	NON-COVERED CHARGES EXCEED BILLED CHARGES
098	BILL CLASS 2 REQUIRES MEDICARE ALLOWED AMOUNT IN LOC#54
101	INVALID EMERGENCY INDICATOR
114	INVALID OR MISSING HCPCS CODE
115	HCPCS CODE NOT ON FILE
120	QUANTITY INVALID/MISSING
127	NDC INVALID/MISSING
131	PRIMARY DIAGNOSIS NOT ON FILE
132	SECONDARY DIAGNOSIS NOT ON FILE
136	NO ELIGIBLE SERVICE PAID - ENCOUNTER DENIED
180	THE ADMISSION DATE WAS NOT A VALID DATE
182	PROCEDURE CLAIM TYPE CONFLICT
183	SURGICAL PROCEDURE NOT ON FILE
186	CERTIFIED REGISTERED NURSE ANESTHETISTS MUST BILL CORRECT MODIFIER
200	PROVIDER/ATTENDING PROVIDER NOT ON FILE
206	BILLING PROVIDER NOT ON FILE
211	DATE OF SERVICE LESS THAN DATE OF BIRTH
212	NO SERVICING PROVIDER NUMBER (ATTENDING PROVIDER MUST BE INDIVIDUAL)
215	RECIPIENT NOT ON FILE
216	RECIPIENT NOT ELIGIBLE ON DATE OF SERVICE
217	NAME AND/OR NUMBER ON CLAIM DOES NOT MATCH FILE RECORD
224	INVALID BIRTHDATE ON RECIPIENT FILE
252	DIAGNOSIS NOT ON FILE
254	DIAGNOSIS AGE RESTRICTION
255	DIAGNOSIS SEX RESTRICTION
258	DIFFERENCE BETWEEN SERVICE DATES AND QUANTITY
260	ANESTHESIA BASE UNITS ARE NOT ON FILE

EDIT CODE	EDIT DISPOSITION – DENY (REPAIRABLE OR REPAIRABLE UNDER LIMITED CIRCUMSTANCES)[1] EDIT DESCRIPTION
269	ANESTHESIOLOGIST CPT NOT COVERED FOR MEDICAID ONLY-BILL SURG+MOD
273	3RD PARTY CARRIER CODE MISSING; REFER TO CARRIER CODE LIST
289	INVALID PROVIDER NUMBER WHEN DENY APPLIED
301	EMERGENCY ACCESS HOSPITAL - NATURE OF ADMISSION MUST BE EMERGENCY
307	SURGICAL PROCEDURE MISSING
309	DATE OF SURGERY MISSING
310	DATE OF SURGERY LESS THAN SERVICE FROM DATE
311	DATE OF SURGERY GREATER THAN SERVICE THRU DATE
316	COVERED DAYS DO NOT EQUAL ACCOMMODATION DAYS
317	STATEMENT DATES CONFLICT WITH ACCOMMODATION DAYS
339	OCCURRENCE CODES/DATES CONFLICT
340	SPAN DAYS/NON COVERED DAYS CONFLICT
344	SPAN FROM THRU DATES CONFLICT
351	SPAN DATE NOT ALLOWED; MUST BILL PER DAY
364	RECIPIENT INELIGIBLE DECEASED
376	ADJUSTMENT DAYS CONFLICT WITH HISTORY DAYS
430	MODIFIER NOT NEEDED-REMOVE AND RESUBMIT
433	MISSING/INVALID DIAGNOSIS CODE
444	MISSING/INVALID SERVICE PROVIDER
506	SUBMITTING PROVIDER IS NOT A SMO (SMO)
513	HCPCS REQUIRED
539	CLAIM REQUIRES DETAILED BILLING
545	REVENUE CODE INVALID FOR REPORTING NDC INFORMATION
702	NEW PATIENT/ESTABLISHED PATIENT CODE CONFLICT
781	INAPPROPRIATE PROCEDURE CODE MODIFIER-REBILL
796	ORIG/ADJ BILLING PROVIDER NUMBER DIFFERENT
799	NO HISTORY RECORD ON FILE FOR THIS ADJUSTMENT
914	UNITS DO NOT MATCH DATES OF SERVICE/CLAIMCHECK

Encounter Correction Process

DHH's FI will send edit code reports to the SMO the day after they are produced by the MMIS adjudication cycle via the web. The SMO is required to submit corrections in accordance with an approved quality assurance plan.

Resubmissions

The SMO may make corrections to the service line(s) to which a repairable edit code was applied.

If an encounter is denied in its entirety, the SMO may resubmit the encounter once it has been corrected.

4

Transaction Testing and EDI Certification

Introduction

The intake of encounter data from the SMO is treated as HIPAA compliant transactions by DHH and its FI. As such, the SMO is required to undergo Trading Partner testing with the FI prior to electronic submission of encounter data. Testing is conducted to verify that the transmission is free of format errors. In order to simulate a production environment, the SMO is requested to send real transmission data. The FI does not define the number of encounters in the transmission; however, DHH will require a minimum set of encounters for each transaction type based on testing needs.

If a SMO rendering contracted provider has a valid NPI and taxonomy code, the SMO will submit those values in the 837. If the provider is an atypical provider, the SMO must follow 837 atypical provider guidelines.

Prior to testing, the SMO must supply DHH with documentation of provider information publicly available through the Freedom of Information Act (FOIA) from the National Provider and Plan Enumeration System (NPPES). The NPI Registry enables you to search for a provider's NPPES information. All information produced by the NPI Registry is provided in accordance with the NPPES Data Dissemination Notice. In addition, DHH will provide the SMO with a list of provider types and specialties. The SMO is to provide the provider type and specialty in addition to the data elements available through NPPES.

Test Process

The Electronic Data Interchange (EDI) protocols are available at:
http://www.lamedicaid.com/provweb1/billing_information/medicaid_billing_index.htm or

www.lmmis.com/provweb1/default.htm and choosing Electronic Claims Submission (EMC). Below are the required steps of the testing process.

Electronic Data Interchange (EDI)

Enrollment as an EDI submitter is achieved through the completion of the DHH/FI approval process and the successful testing of provider encounters of a particular claim type. The FI EDI Coordinator is available to assist in answering questions, but enrollment and participation proceed through the following steps:

- Upon request from the SMO, the FI will provide application and approval forms for completion by the submitter. When completed, these forms must be submitted to the FI Provider Enrollment Unit.
- During the authorization process, the SMO can call the EDI Department to receive EDI specifications that contain the data and format requirements for creating EDI claims. Using these specifications, the potential submitter develops and tests application software to create EDI encounters.
- Molina requires the SMO to certify with a third-party vendor, EDIFECS, prior to submitting test claims to Molina.
- When the submitter is ready to submit a file of test encounters, the test encounters shall be submitted to the FI EDI Coordinator using the submitter number: 4509999. The test submission is run through Louisiana Medicaid Management Information System (MMIS) programs that validate the data and formats. Reports produced from this testing are reviewed by the FI. The test results are verified and the submitter is contacted to review any problems with the submission. If necessary, additional test encounters will be submitted until an acceptable test run is completed. **This test submitter number (4509999) shall be used for submission of test encounters only!**

When all forms have been received and approved by the FI's Provider Enrollment Unit, and the EDI Department has verified the test claims, the submitter will be notified that EDI encounters may be submitted.

Once the SMO becomes an approved EDI submitter, the billing process will be as follows:

- Upon receipt of the submission, the FI's EDI Department logs the submission and verifies it for completeness. If the submission is not complete, the log is rejected and the submitter is notified about the reject reason(s) via electronic message or telephone call.
- If the certification form is complete, the EDI Department enters the submitted encounters into a pre-processor production run. The pre-processor generates an encounter data file and one report. The Claims Transmittal Summary report, which

lists whether a provider's batch of encounters has been accepted or rejected, is generated for each submission. If a provider's encounters are rejected, the provider number, dollar amount and number of encounters are listed on the report.

The SMO will submit to DHH and its FI a test plan with systematic plans for testing the ASC X12N 837 COB. The plan consists of three (3) tiers of testing, which are outlined in Appendix H.

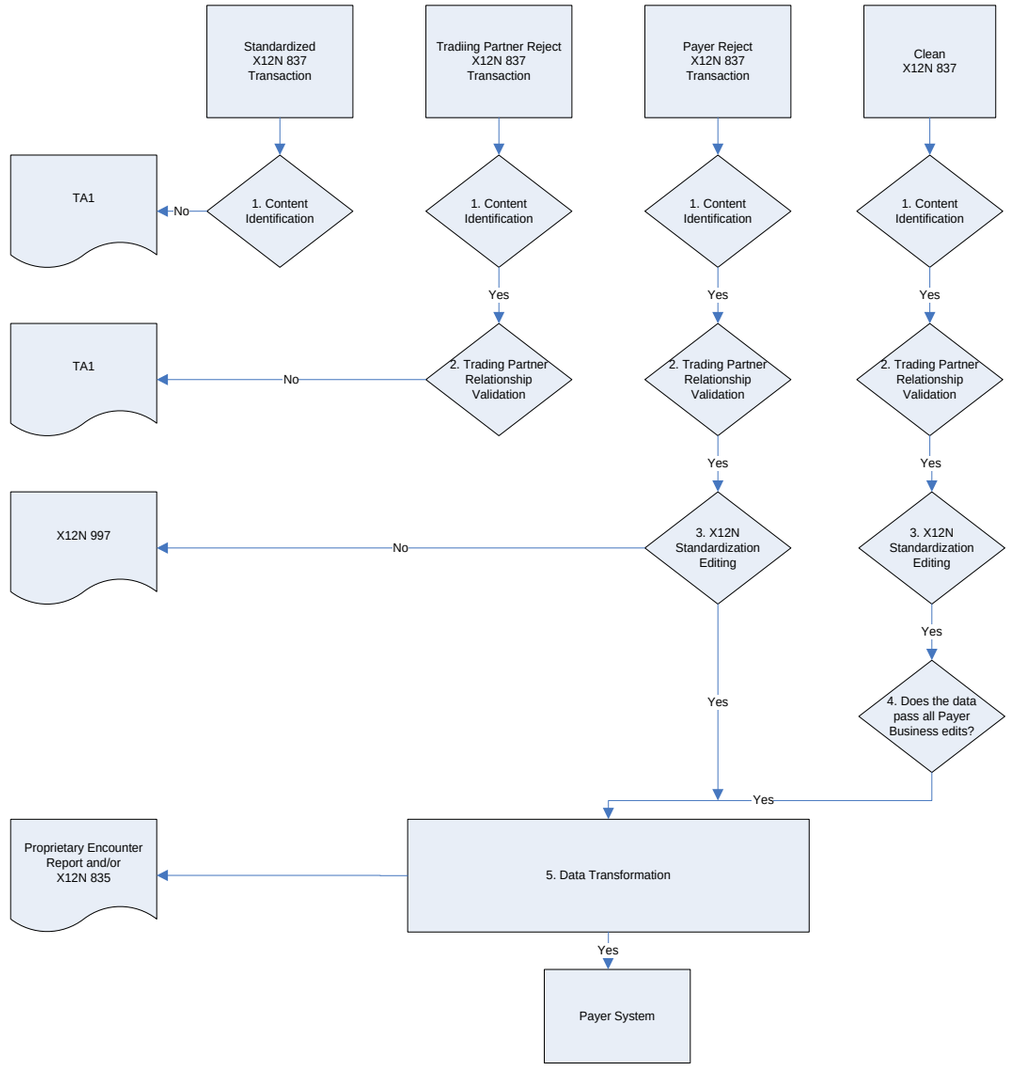
Timing

The SMO may initiate EDIFECS testing at any time. DHH's FI Business Support Analysts are ready to answer technical questions and to arrange testing schedules and EDIFECS enrollment. Please refer to the FI Companion Guides for specific instructions, located at: www.lamedicaid.com/provweb1/HIPAABilling/HIPAAindex.htm

Editing and Validation Flow Diagram

The following process flow chart depicts an incoming ANSI ASC X12N 837 transaction validation for syntax of the FI Electronic Data Interchange (EDI).

Molina Electronic Data Interchange (EDI):
Incoming ANSI ASC X12N 837
Transaction Validation for Syntax



Data Certification

The BBA requires that when State payments to the SMO are based on data that is submitted by the SMO, the data must be certified. This certification applies to enrollment data, encounter data, and any other information that is specified by the State. The certification must attest, based on best knowledge, information, and belief, to the accuracy, completeness, and truthfulness of the data and any documents submitted as required by the State. Encounter files submitted by the SMO, which are used to create payments and/or capitated rates, must be certified by a completed signed Data Certification form, which is required to be faxed concurrently with each encounter submission. The data must be certified by one of the following individuals:

1. SMO's Chief Executive Officer (CEO); or
2. SMO's Chief Financial Officer (CFO); or
3. An individual who has the delegated authority to sign for, and who reports directly to the CEO or CFO.

Certification shall be submitted concurrently with the certified data.

5

Data Management and Error Correction Process

Introduction

Encounter data is submitted through the FI's Electronic Data Interchange (EDI). Once received, 837 transactions are subject to initial edits. Further edits are applied during MMIS encounter processing.

Rejection Criteria

Incoming 837s may be rejected either at the FI's Electronic Data Interchange (EDI) or during the MMIS encounter processing. At the FI's Electronic Data Interchange (EDI), there are four levels (batch, syntax, claim header or service line) where edits (data validation processes) are present. Rejection of an entire batch or a single encounter is designated by the edit level in which the error occurs. Line level errors may also occur in the MMIS processing system. DHH will require The SMO to correct certain MMIS line level errors.

Entire File

Rejection of an entire batch is designated by the edit level in which the error occurs. Interchange Level Errors will result in the rejection of an entire batch and the generation of a TA1 Rejection Report.

The TA1 is an ANSI ASC X12N Interchange Acknowledgement segment that is used to report receipt of individual envelopes. An interchange envelope contains the sender, receiver, and data type information for the header. If the syntactical analysis of the interchange header and trailer is invalid, the interchange will reject and a TA1 will be

forwarded to the Molina Call Center. In this scenario, the entire transaction is rejected at the header level.

Once the transaction has passed interchange edits, it shall be subject to transaction set syntax errors. If the error occurs at the ST or SE level segments, the entire transaction is rejected. These edits are reported on the ANSI ASC X12N 997.

Claim

Transactions with errors at the ST or SE level segments are rejected in their entirety. However, if the functional group consists of additional transactions without errors, these transactions are processed. The 997 transaction contains ACCEPT or REJECT information. If the file contains syntactical errors, the segment(s) or elements(s) where the error(s) occurred are reported.

Once the transaction has passed through syntactical edits, the transaction is edited according to implementation guide rule sets and payer-specific requirements. Any errors that occur at this level will result in the data content within that encounter being rejected. The ANSI ASC X12N 824 may be used to report those errors.

Service Line

Data that passes the FI's edits will proceed to the data transformation step for processing. In this step, certain data elements are converted into a format that is acceptable for claims processing. During processing, the MMIS will apply specific edits to the encounters. Depending upon the level of edit, an individual encounter may deny at the header or at a single detailed line.

A full listing of encounter edits is contained in Appendix F. After processing, an 835 Remittance Advice is returned to the sender.[2]

Error Correction Process

The SMO is required to correct and resubmit any transactions or encounters that are rejected in their entirety. For service line rejections, the SMO is required to correct and resubmit errors that are known to be "repairable". A list of repairable denials is contained in Section 3 of this Guide.

Entire File

The SMO will receive either a TA1 or X12N 997 error report. The SMO is required to work with the FI's Business Support Analysts to determine the cause of the error.

[2] If requested by the BH-MCO and prearranged with DHH

Claim

The SMO will receive either an X12 835 or proprietary reports for header level rejections. The SMO is responsible for adherence to the implementation guide, code sets, and looping structures for the transaction. The SMO will also be responsible for adhering to the DHH payer-specific data rules, as defined in the FI's Companion Guide and Section 2 of this Guide.

Service Line

The SMO will receive an X12N 835 for transaction claims that have processed through the MMIS. If the service line fails MMIS encounter edits, an adjustment reason code, adjustment amount, and adjustment quantity are returned in the CAS segment of loop 2110.

This CAS segment is optional and is intended to reflect reductions in payment due to adjustments particular to a specific service in the encounter. An example of this level of CAS is the reduction for the part of the service charge that exceeds the usual and customary charge for the service. See 2.2.1, Balancing, and 2.2.4, Claim Adjustment and Service Adjustment Segment Theory in the 835 IG, for additional information.

A single CAS segment contains six repetitions of the “adjustment trio” composed of adjustment reason code, adjustment amount, and adjustment quantity. These six adjustment trios are used to report up to six adjustments related to a particular Claim Adjustment Group Code (CAS01). The first adjustment is reported in the first adjustment trio (CAS02-CAS04). If there is a second non-zero adjustment, it is reported in the second adjustment trio (CAS05-CAS07), and so on through the sixth adjustment trio (CAS17-CAS19).

Each adjustment reason is associated with a particular MMIS edit code. The SMO is presented with an edit code report to assist them in identifying repairable errors. The SMO is responsible for correcting and resubmitting service line denials.

Outstanding Issues

After implementing the data management and error correction process and any processing error(s) remaining unresolved, the SMO may present the outstanding issue(s) to DHH and/or its FI for clarification or resolution. DHH and/or its FI will review the issue(s) and triage the issue(s) to the appropriate entity for resolution, and respond to the SMO with their findings. If the outcome is not agreeable to the SMO, the SMO can re-submit the outstanding issue(s) with supporting documentation to DHH for reconsideration. The outcome as determined by DHH will prevail.

Dispute Resolution

The SMO has the right to file a dispute regarding rejected encounters. Disputes must be filed within thirty (30) days of identifying an issue for dispute. The SMO may believe that a rejected encounter is the result of a "FI error." A FI error is defined as a rejected encounter that (1) the FI acknowledges to be the result of its own error, and (2) requires a change to the system programming, an update to MMIS reference tables, or further research by the FI, and therefore requires FI resolution to process the rejection.

The SMO must notify DHH in writing within thirty (30) calendar days if it believes that the resolution of a rejected encounter rests on the FI rather than the SMO. The FI, on behalf of DHH, will respond in writing within thirty (30) days of receipt of such notification. DHH encourages the SMO to provide written notice as soon as possible. The FI response will identify the status of each rejected encounter problem or issue in question.

For ease in filing written requests, the SMO may use the Edit Reports provided by the FI. The SMO shall highlight, or otherwise note, the rejected encounters to be researched, and attach a memorandum describing the problem.

The FI will review the SMO's notification and may ask the SMO to research the issue and provide additional substantiating documentation, or the FI may disagree with the SMO's claim of an FI error. If a rejected encounter being researched by the FI is later determined not to be caused by the FI, the SMO will be required to make corrections to the encounter, if appropriate, and resubmit during the next billing cycle.

6

Continuous Quality Improvement

Introduction

In accordance with the BBA, DHH-OBH developed a quality strategy plan that serves as the guiding principles for the establishment of quality improvement efforts for the SMO. Continuous quality improvement is the method to identify opportunities for improving and demonstrating successful interventions for data management. Data from the SMO will continue to undergo data quality checks beyond the minimum criteria used in the MMIS edit process. The result of edits and data quality improvement monitoring are combined to develop plan-specific encounter quality improvement plans. Interim monitoring and follow-up on identified quality problem areas is an integral component of DHH's encounter process.

The encounter quality improvement plan is designed to provide DHH-OBH and the SMO with a comprehensive list of data quality issues present in the data for a given period at the time of the report. DHH-OBH will meet with the SMO every three (3) months, or as needed. The encounter quality improvement plans are sent by the SMO to DHH-OBH in advance of the meeting. The SMO meeting attendees are to include claims and EDI experts, and clinical quality assurance staff.

At the site visit, the SMO is expected to have investigated the findings of encounter quality improvement plans and be prepared to explain the underlying reasons for the identified data quality issue(s). As data issues are discussed, the SMO must incorporate corrective action steps into a quality improvement report. If issues are not resolved in a timely manner, DHH-OBH may request a corrective action plan (CAP). The CAP shall include a listing of issues, responsible parties, and projected resolution dates.

Minimum Standards

There are three components to encounter data quality assessment: Repairable Denials and Data Volume Assessment.

Repairable Denials

Repairable denials must be recorded on the encounter quality improvement plan with a corrective action plan for correcting and resubmitting encounters with line level denials or full encounter denials.

Data Volume Assessment

Data Volume Assessment refers to the evaluation of whether key services meet expected rates of provision, as demonstrated in the data. This is important to decide whether plans are submitting data and, ultimately, whether the actual level of services are adequate to meet contractual requirements, justify capitation rates, and provide appropriate access to care for the enrolled population. A core audit function includes determining whether DHH-OBH has all of the encounter data generated for a specific period.

Children's Invoices Match Submitted Encounter Data

The invoices submitted by Magellan for Medicaid children's services must match the encounter data accepted by the MMIS. Payment for services will not be rendered for unsubstantiated invoices.

7

Adjustment Process

Introduction

In the case of adjustments, the SMO is to follow the detailed, payer-specific instructions provided in the FI's Companion Guides found at:

www.lamedicaid.com/provweb1/HIPAABilling/HIPAAindex.htm.

To adjust an encounter with a line level denial, make the correction(s) to the encounter and resubmit using the instructions below.

Line Adjustment Process

Loop	Segment	Data Element	Comments
2300	CLM05-3	1325	**Claim Frequency Type Code** To adjust a previously submitted claim, submit a value of "**7**". See also 2300/REF02.
2300	REF01	128	**Reference Identification Qualifier** To adjust a previously submitted claim, submit "**F8**" to identify the Original Reference Number.
2300	REF02	127	**Original Reference Number** To adjust a previously submitted claim, please submit the **13-digit ICN** assigned by the adjudication system and printed on the remittance advice, for the previously submitted claim that is being

			adjusted by this claim.

For claim level denials, make the correction(s) and resubmit.

Molina ICN Format

The format of the Molina ICN is as follows:

- Digit 1 = Last digit of year of receipt
- Digits 2-4 = Julian day of the year of receipt
- Digit 5 = Media Code with value of 1(EDI)
- Digits 6-8 = 3 digit batch number
- Digits 9-11 = 3 digit sequential number in batch
- Digit 12-13 = claim line number

Appendix A

Definition of Terms

The following terms shall be construed and interpreted as follows unless the context clearly requires otherwise.

837 Format	The file format used for electronic billing of professional services, institutional services or dental services. ANSI 837 is shorthand for the ASC X12N 837 (004010X098A1) file format.
997 Functional Acknowledgment	Transaction set-specific verification is accomplished using a 997 Functional Acknowledgement. The transaction set can be used to define the control structures for a set of acknowledgments to indicate the results of the syntactical analysis of the electronically encoded documents.
Administrative Region	Legislation has mandated that the administration of the Louisiana MH care system transition from inter-related geographic regions to a system of independent health care districts or authorities (also referred to as local governing entities or LGEs) under the general administration of DHH-OBH. Individuals in five regions may enroll in the CSoC 1915(c) SED waiver on March 1, 2012:

	Region 2 includes the parishes of East Baton Rouge, East Feliciana, Iberville, Pointe Coupee, West Baton Rouge, and West Feliciana. Region 7 includes the parishes of Avoyelles, Catahoula, Concordia, Grant, LaSalle, Rapides, Vernon, and Winn. Region 8 includes the parishes of Bienville, Bossier, Caddo, Claiborne, Desoto, Jackson, Natchitoches, Red River, Sabine, and Webster. Region 9 includes the parishes of Caldwell, East Carroll, Franklin, Lincoln, Madison, Morehouse, Ouachita, Richland, Tensas, Union, and West Carroll. Jefferson Parish (Part of Act 1225 Region 1)
Agent	Any person or entity with delegated authority to obligate or act on behalf of another party.
Atypical providers	Individuals or businesses that bill Medicaid for services rendered, and do not meet the definition of a health care provider according to the NPI Final Rule 45 CFR 160.103 (e.g., carpenters, transportation providers, etc).
Benefits or Covered Services	Those health care services to which an eligible Medicaid recipient is entitled under the Louisiana Medicaid State Plan and waivers.
CAS Segment	Used to report claims or line level adjustments.
Centers for Medicare and Medicaid Services (CMS)	The agency within the U.S. Department of Health & Human Services that provides administration and funding for Medicare under Title XVIII, Medicaid under Title XIX, and the Children's Health Insurance Program under Title XXI of the Social Security Act. This agency was formerly known as the Health Care Financing Administration (HCFA).
Claim	A request for payment for benefits received or services rendered.
Claim adjustment	A reason why a claim or service line was paid differently than it was billed. Adjustments are

	communicated by adjustment reason codes.
Claim denial	When a claim does not meet the criteria of being complete or does not meet all of the criteria for payment under health plan rules.
Claims adjudication	In health insurance claims, adjudication refers to the determination of the insurer's payment or financial responsibility, after the member's insurance benefits are applied to a medical claim.
Clean claim	A claim that has no defect or impropriety (including any lack of required substantiating documentation) or particular circumstance requiring special treatment that prevents timely payment of the claim. It does not include a claim from a provider who is under investigation for fraud or abuse or a claim under review for medical necessity.
Core Benefits and Services	A schedule of health care benefits and services required to be provided by the SMO to Medicaid LABHP members as specified under the terms and conditions of the RFP and Louisiana Medicaid State Plan and waivers as outlined in the contract's service manual.
CMS 1500	A universal claim form, required by CMS, to be used by non-institutional and institutional providers that do not use the UB-92.
CommunityCARE 2.0	Refers to the Louisiana Medicaid Primary Care Case Management (PCCM) program, which links Medicaid enrollees to a primary care provider as their medical home.
BAYOU HEALTH Network	An entity designed to improve performance and health outcomes through the creation of cost effective integrated healthcare delivery system that provides a continuum of evidence-based, quality-driven healthcare services for Medicaid eligibles.
Coordination of Benefits (COB)	Refers to the activities involved in determining Medicaid benefits when a recipient has coverage through an individual, entity, insurance, or program that is liable to pay for

	health care services.
CSoC	Coordinated System of Care
CSoC eligible	Children and youth eligible for the CSoC
Co-payment	Any cost sharing payment for which the Medicaid BH-MCO member is responsible for in accordance with 42 CFR § 447.50 and Section 5006 of the American Recovery and Reinvestment Act (ARRA) for Native American members.
Core Benefits and Services	A schedule of health care benefits and services required to be provided by the SMO to Medicaid LABHP members as specified under the terms and conditions of the RFP and Louisiana Medicaid State Plan and waivers.
Corrective Action Plan (CAP)	A plan developed by the BH-MCO that is designed to ameliorate an identified deficiency and prevent reoccurrence of that deficiency. The CAP outlines all steps/actions and timeframes necessary to address and resolve the deficiency.
Corrupt data	Data corruption refers to errors in electronic data that occur during transmission, retrieval, or processing, introducing unintended changes to the original data. Computer storage and transmission systems use a number of measures to provide data integrity and the lack of errors. In general, when there is a Data Corruption, the file containing that data would be inaccessible, and the system or the related application will give an error. There are various causes of corruption.
Covered Services	Those health care services/benefits to which an individual eligible for Medicaid is entitled under the Louisiana Medicaid State Plan and waivers as outlined in the contract's service manual.
Data Certification	The Balanced Budget Act (BBA) requires that when State payments to a BH-MCO (SMO)

	are based on data that is submitted by the BH-MCO, the data must be certified. This certification applies to enrollment data, encounter data, and any other information that is specified by the State. The certification must attest, based on best knowledge, information, and belief, to the accuracy, completeness, and truthfulness of the data and any documents submitted as required by the State.
Denied claim	A claim for which no payment is made to the network provider by the SMO for any of several reasons, including but not limited to, the claim is for non-covered services, the provider or Member is ineligible, the claim is a duplicate of another transaction, or the claim has failed to pass a significant requirement (or edit) in the claims processing system.
Department (DHH)	The Louisiana Department of Health and Hospitals, referred to as DHH.
Department of Health and Human Services (DHHS; also HHS)	The United States government's principal agency for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves. The DHHS includes more than 300 programs, covering a wide spectrum of activities, including medical and social science research; preventing outbreak of infectious disease; assuring food and drug safety; overseeing Medicare, Medicaid and CHIP; and providing financial assistance for low-income families.
Dispute	An expression of dissatisfaction about any matter other than an action, as action is defined. Examples of a Dispute include dissatisfaction with quality of care, quality of service, rudeness of a provider or a network employee, and network administration practices. Administrative Disputes are generally those relating to dissatisfaction with the delivery of administrative services, coverage issues, or access to care issues.
Duplicate claim	A claim that is either a total or a partial

	duplicate of services previously paid.
Early and Periodic Screening, Diagnosis and Treatment (EPSDT)	A federally required Medicaid benefit for individuals under the age of 21 years that expands coverage for children and adolescents beyond adult limits to ensure availability of 1) screening and diagnostic services to determine physical or mental defects and 2) health care, treatment, and other measures to correct or ameliorate any defects and chronic conditions discovered (CFR 440.40 (b)). EPSDT requirements help to ensure access to all medically necessary health services within the federal State Plan definition of "medical assistance". Note: 1915(c) waiver services for children are not covered under EPSDT.
Edit Code Report	A proprietary report prepared by the Fiscal Intermediary that includes all of the edit codes for each claim line and each claim header. Some edit codes indicate that the encounter has denied. Other edit codes are informational only.
EDI Certification	EDI Certification essentially provides a snapshot that asserts an entity is capable at that point in time of generating or receiving compliant files. It is based solely on the files that have been tested and submitted for certification. Specifically, it is based on the exact capabilities that are reflected within those files. Testing and certification are typically done through a third party vendor prior to encounters being submitted to the Fiscal Intermediary.
Eligible	An individual qualified to receive services through the SMO, consistent with the eligibility requirements of DHH, DCFS, OJJ, DOE, and the local education agencies.
Emergency Medical Condition	A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to

	result in: (1) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (2) serious impairment to bodily functions, or (3) serious dysfunction of any bodily organ or part. Emergency care requires immediate face-to-face medical attention.
Encounter data	Records of medically-related services rendered by a provider to the SMO Member on a specified date of service. This data is inclusive of all services for which the SMO has any financial liability to a provider. Encounter data must be submitted for both the risk adult and non-risk children's, retroactive and spend down claims.
Enrollee	A Louisiana Medicaid or CHIP eligible (recipient) who is currently enrolled in the SMO. This definition may also include a person who is qualified for Medicaid and whose application has been approved but who may or may not be receiving services.
Enrollment	The process conducted by DHH to enroll a Medicaid or CHIP eligible into the SMO.
Evidence-Based Practice	Clinical interventions that have demonstrated positive outcomes in several research studies to assist individuals in achieving their desired goals of health and wellness.
External Quality Review Organization (EQRO)	An organization that meets the competence and independence requirements set forth in 42 CFR 438.354, and performs EQR, and other related activities as set forth in federal regulations, or both.
Federally Qualified Health Center (FQHC)	An entity that receives a grant under Section 330 of the Public Health Service Act, as amended, (also see Section 1905(1) (2) (B) of the Social Security Act), to provide primary health care and related diagnostic services and may provide dental, optometric, podiatry, chiropractic and behavioral health services.
Fee for Service (FFS)	A method of provider reimbursement based on payments for specific services rendered to an enrollee.

File Transfer Protocol (FTP)	Software protocol for transferring data files from one computer to another with added encryption.
Fiscal Intermediary (FI) for Medicaid	DHH's designee or agent responsible in the current delivery model for an array of support services including MMIS development and support, claims processing, pharmacy support services, provider support services, financial and accounting systems, prior authorization and utilization management, fraud and abuse systems, and decision support.
Fiscal Year (FY)	Refers to budget year – A Federal Fiscal Year is October 1 through September 30 (FFY); A State Fiscal Year is July 1 through June 30 (SFY).
Fraud	As it relates to the Medicaid Program Integrity, means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him or some other person. It includes any act that constitutes fraud under applicable Federal or State law. Fraud may include deliberate misrepresentation of need or eligibility; providing false information concerning costs or conditions to obtain reimbursement or certification; or claiming payment for services which were never delivered or received.
Health Care Professional	A physician or other health care practitioner licensed, accredited, or certified to perform specified health services consistent with State law.
Health Care Provider	A health care professional or entity that provides health care services or goods.
Healthcare Effectiveness Data and Information Set (HEDIS)	A set of performance measures developed by the National Committee for Quality Assurance (NCQA). The measures were designed to help health care purchasers understand the value of health care purchases and measure plan (i.e., BH-MCO) performance.

HIPAA – Health Insurance Portability Administration Act	The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA, Title II) required the Department of Health and Human Services (HHS) to establish national standards for electronic health care transactions and national identifiers for providers, health plans, and employers. As the industry has implemented these standards, and increased the use of electronic data interchange, the nation's health care system will become increasingly effective and efficient.
ICD-9-CM codes (International Classification of Diseases, 9th Revision, Clinical Modification)	Codes currently used to identify diagnoses. The SMO shall move to ICD-10-CM as it becomes effective.
Immediate	In an immediate manner; instant; instantly or without delay, but not more than 24 hours.
Information Systems (IS)	A combination of computing hardware and software that is used in: (a) the capture, storage, manipulation, movement, control, display, interchange and/or transmission of information, *i.e*. structured data (which may include digitized audio and video) and documents; and/or (b) the processing of such information for the purposes of enabling and/or facilitating a business process or related transaction.
Interchange Envelope	Trading partners shall follow the Interchange Control Structure (ICS), Functional Group Structure (GS), Interchange Acknowledgment (TA1), and Functional Acknowledgement (997) guidelines for HIPAA that are located in the HIPAA Implementation Guides in Appendix A and B.
Internal Control Number (ICN)	DHH's FI assigns each claim an Internal Control Number (ICN) systematically when it is received electronically or by mail. Processing or returning the claim constitutes the FI's final action on that claim. A resubmission of the same claim is considered a new claim. Each claim sent to the FI is assigned an ICN automatically, which is used

	to track the claim. The ICN is made up of 13 digits following a specific format. The format of the ICN enables you to determine when the FI actually received the claim.
Louisiana Behavioral Health Partnership	The behavioral health program managed by DHH-OBH that includes behavioral health services for a special target population of children eligible for the Coordinated System of Care (CSoC); adults with serious mental illness (SMI); and the SMO child/adult population (e.g., the rest of the non-institutionalized Medicaid population). The benefit package for this third population includes inpatient psychiatric care, emergency room care, substance abuse services and care by psychiatrists for all adults and children. It also includes all EPSDT behavioral health care services for all Medicaid children. This population could be referred to as a traditional behavioral health "carve-out" program. The Louisiana Behavioral Health Partnership managed by DHH-OBH oversees the Behavioral Statewide Management Organization (SMO), the prepaid inpatient health plan (PIHP) that implements the 1) 1915(b) waiver; 2) the 1915(i) Adult Mental Health Rehabilitation services for the Severely Mentally Ill; and 3) the CSoC – 1915(c) SED Children's waiver. The mental health and substance abuse PIHP is at-risk for adult services including adults with limited mental health and substance abuse benefits and is paid on a non-risk basis for children's services and any individual with retroactive eligibility and spend-down beneficiaries in the month they meet their spend-down. Adults are eligible under the PIHP for State Plan services including care by psychiatrists, inpatient psychiatric care, emergency rooms, and substance abuse rehabilitation services. Children are eligible under the PIHP for those State Plan services as well as all medically necessary EPSDT services. The SMO will also manage behavioral health services for Non-Medicaid eligible populations served by OBH, DCFS, and OJJ, and funded through state general funds and block grants,

	including services for individuals with co-occurring mental health and addictive conditions.
Louisiana Department of Health and Hospitals (DHH)	The state department responsible for promoting and protecting health and ensuring access to medical, preventive and rehabilitative services for all citizens in the state of Louisiana.
Medicaid	A means tested federal-state entitlement program enacted in 1965 by Title XIX of the Social Security Act. Medicaid offers federal matching funds to states for costs incurred in paying health care providers for serving eligible individuals.
Medicaid FFS Provider	An institution, facility, agency, person, corporation, partnership, or association that has signed a PE 50 agreement, has been approved by DHH, and accepts payment in full for providing benefits, the amounts paid pursuant to approved Medicaid reimbursement provisions, regulations and schedules.
Medicaid Management Information System (LMMIS)	A mechanized claims processing and information retrieval system, which all states Medicaid programs are required to have, and which must be approved by the Secretary of DHHS. This system is an organized method of payment for claims for all Medicaid services and includes information on all Medicaid Providers and Eligibles.
Medicaid Recipient	An individual who has been determined eligible, pursuant to federal and state law, to receive medical care, goods or services for which DHH may make payments under the Medicaid or CHIP Program, who may or may not be currently enrolled in the Medicaid or CHIP Program, and on whose behalf payment is made.
Medical Vendor Administration (MVA)	The name for the budget unit specified in the Louisiana state budget that contains the Bureau of Health Services Financing (Louisiana's single state Medicaid Agency).

Medically Necessary Services	Health care services that are in accordance with generally accepted, evidence-based medical standards, or that are considered by most physicians (or other independent licensed practitioners) within the community of their respective professional organizations to be the standard of care. In order to be considered medically necessary, services must be: 1) deemed reasonably necessary to diagnose, correct, cure, alleviate or prevent the worsening of a condition or conditions that endanger life, cause suffering or pain or have resulted or will result in a handicap, physical deformity or malfunction; and 2) not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease. Any such services must be clinically appropriate, individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and neither more nor less than what the patient requires at that specific point in time. Services that are experimental, non-FDA approved, investigational, cosmetic, or intended primarily for the convenience of the recipient or the provider, are specifically excluded from Medicaid coverage and will be deemed "not medically necessary". The Medicaid Director, in consultation with the Medicaid Medical Director, may consider authorizing such a service in his discretion on a case-by-case basis.
Medicare	The federal medical assistance program in the United States authorized in 1965 by Title XVIII of the Social Security Act, to address the medical needs of older American citizens. Medicare is available to U.S. citizens 65 years of age and older and some people with disabilities under age 65.
Member	Persons enrolled in the SMO.
National Provider Identifier (NPI)	The National Provider Identifier (NPI) is a Health Insurance Portability and

	Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number for covered health care providers. Covered health care providers and all health plans and health care clearinghouses must use the NPIs in the administrative and financial transactions adopted under HIPAA. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). This means that the numbers do not carry other information about healthcare providers, such as the state in which they live or their medical specialty. The NPI must be used in lieu of legacy provider identifiers in the HIPAA standards transactions.
Network	As used in the Contract, "network" may be defined as a group of participating providers linked through contractual arrangements to a SMO to supply a range of behavioral health care services. The term "provider network" may also be used.
Non-Contracting Provider	A person or entity that provides hospital or medical care, but does not have a contract, or agreement with the BH-MCO.
Non-Covered Services	Services not covered under the Title XIX Louisiana State Medicaid Plan.
Non-Emergency	An encounter by a BH-MCO member who has presentation of medical signs and symptoms, to a health care provider, and not requiring immediate medical attention.
Performance Measures	Specific operationally defined performance indicators utilizing data to track performance and quality of care and to identify opportunities for improvement related important dimensions of care and service.
Policies	The general principles by which DHH is guided in its management of the Title XIX program, and as further defined by DHH promulgations and by state and/or federal rules and regulations.

Primary Care Provider (PCP)	An individual physician or other licensed nurse practitioner responsible for the management of a member's health care who is licensed and certified in one of the following general specialties; family practitioner, general practitioner, general pediatrician, general internal medicine, general internal medicine and pediatrics, or obstetrician/ gynecologist. The primary care provider is the patient's point of access for preventive care or an illness and may treat the patient directly, refer the patient to a specialist (secondary/tertiary care), or admit the patient to a hospital.
Primary Care Services	Health care services and laboratory services customarily furnished by or through a primary care provider for diagnosis and treatment of acute and chronic illnesses, disease prevention and screening, health maintenance, and health promotion either through, direct service to the member when possible, or through appropriate referral to specialists and/or ancillary providers.
Prior Authorization	The process of determining medical necessity for specific services before they are rendered.
Prospective Review	Utilization review conducted prior to an admission or a course of treatment.
Protected Health Information (PHI)	Individually identifiable health information that is maintained or transmitted in any form or medium and for which conditions for disclosure are defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) 45 CFR Part 160 and 164.
Provider	Either (1) for the Fee-For-Service Program, any individual or entity furnishing Medicaid services under an agreement with the Medicaid agency; or (2) for the BH-MCO Program, any individual or entity that is engaged in the delivery of health care services and is legally authorized to do so by the State in which it delivers services.

Provider Specialty	A second-level qualification code, specific to Louisiana Medicaid, that designates the specialty classification of a provider according to Louisiana State Plan for Medicaid (for example, for physicians, some specialties are General Practice, Pediatrics, Family Medicine, etc.).
Provider Type	A high-level identification code, specific to Louisiana Medicaid, that designates the service classification of a provider according to Louisiana State Plan for Medicaid (for example, physician, dentist, pharmacy, hospital, etc.).
Quality	As it pertains to external quality, review means the degree to which a BH-MCO increases the likelihood of desired health outcomes of its enrollees through its structural and operational characteristics and through the provision of health services that are consistent with current professional knowledge.
Quality Assessment and Performance Improvement Program (QAPI Program)	Program that objectively and systematically defines, monitors, evaluates the quality and appropriateness of care and services, and promotes improved patient outcomes through performance improvement projects, medical record audits, performance measures, surveys, and related activities.
Quality Management (QM)	The ongoing process of assuring that the delivery of covered services is appropriate, timely, accessible, available and medically necessary and in keeping with established guidelines and standards and reflective of the current state of medical and behavioral health knowledge.
Readiness Review	Refers to the process where DHH assesses the SMO's ability to fulfill the requirements of the provider agreement. Such review may include, but is not limited to, review of proper licensure, operational protocols, SMO standards, and systems. The review may be completed as a desk review, on-site review, or

	combination, and may include interviews with pertinent personnel so that DHH can make an informed assessment of the SMO's ability and readiness to render services.
Recipient	An individual entitled to benefits under Title XIX of the Social Security Act, and under the Louisiana Medicaid State Plan who is or was enrolled in Medicaid and on whose behalf a payment has been made for medical services rendered.
Reject	Syntax validation will determine as to whether the data is a valid ANSI ASC X12N. A 997 (Functional Acknowledgement**)** will be returned to the submitter. The 997 contains **ACCEPT** or **REJECT** information. If the file contains syntactical errors, the segment(s) or element(s) where the error(s) occurred will be reported.
Remittance Advice	An electronic listing of transactions for which payment is calculated. Hard copies are available upon request only. Transactions may include but are not limited to, members enrolled in the BH-MCO, payments for maternity, and adjustments.
Repairable Edit Code	An encounter that denies for a reason that is repairable (shall be fixed and resubmitted) will have an accompanying "repairable edit code "code" to indicate that the encounter is repairable.
Representative	Any person who has been delegated the authority to obligate or act on behalf of another. Also known as the authorized representative.
Risk	The chance or possibility of loss. Risk is also defined in insurance terms as the possibility of loss associated with a given population.
Risk adjustment	A method for determining adjustments of the PMPM rate that accounts for variation in health risks among participating health plans when determining per capita prepaid payment. The SMO will not be risk adjusted.

Rural Health Clinic (RHC)	A clinic located in an area that has a healthcare provider shortage that provides primary health care and related diagnostic services and may provide optometric, podiatry, chiropractic and behavioral health services; and which must be reimbursed on a prospective payment system.
SE Segment	The 837 transaction set trailer.
Security Rule (45 CFR Parts 160 & 164)	Part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) which stipulates that covered entities must maintain reasonable and appropriate administrative, physical, and technical safeguards to protect the confidentiality, integrity, and availability of their Electronic Protected Health Information against any reasonably anticipated risks.
Service Area	This is not applicable for the SMO. The SMO will be statewide for the LBHP. See the regions above for the first phase implementation of the CSOC program.
Service Line	A single claim line as opposed to the entire claim or the claim header.
Shall	Denotes a mandatory requirement.
Should, May, Can	Denotes a preference but not a mandatory requirement.
Social Security Act	The current version of the Social Security Act of 1935 (42 U.S.C.A. § 301 et seq.) as amended which encompasses the Medicaid Program (Title XIX) and CHIP Program (Title XXI).
Span of Control	Information systems and telecommunications capabilities that the SMO itself operates, or for which it is otherwise legally responsible according to the terms and conditions of the Contract with DHH-OBH. The span of control also includes systems and telecommunications capabilities outsourced by the SMO

ST Transaction Set Header	Indicates the start of a transaction set and to assign a control number.
Start-Up Date	The date SMO providers begin providing behavioral health services to their Medicaid members. Also referred to as “go-live date”.
State	The state of Louisiana.
Stratification	The process of partitioning data into distinct or non-overlapping groups.
Surveillance and Utilization Review Subsystems (SURS) Reporting	Surveillance and Utilization Review Subsystems is reporting as required in the subsection under Fraud, Abuse and Waste Prevention.
Syntactical Error	Syntax is the term associated with the "enveloping" of EDI messages into interchanges. Items included in Syntax Set maintenance include: "Delimiters" which separate individual elements and segments within the interchange; "Envelope segments" which denote the beginning and ending of messages, functional groups, and interchanges; and "Permitted Characters" which define the values allowed for a particular syntax set. Syntax validation will determine as to whether the data is a valid ANSI ASC X12N. A 997 (Functional Acknowledgement**)** will be returned to the submitter. The 997 contains **ACCEPT** or **REJECT** information. If the file contains syntactical errors, the segment(s) or element(s) where the error(s) occurred will be reported.
System Function Response Time	Based on the specific sub function being performed: • *Record Search Time*-the time elapsed after the search command is entered until the list of matching records begins to appear on the monitor. • *Record Retrieval Time*-the time elapsed after the retrieve command is entered until the record data begin to appear on the monitor.

	• *Print Initiation Time*- the elapsed time from the command to print a screen or report until it appears in the appropriate queue. • *On-line Claims Adjudication Response Time*- the elapsed time from the receipt of the transaction by the SMO from the provider and/or switch vendor until the SMO hands-off a response to the provider and/or switch vendor.
System Availability	Measured within the SMO's information system span of control. A system is considered not available when a system user does not get the complete, correct full-screen response to an input command within three (3) minutes after depressing the "enter" or other function key.
TA1	The Interchange or TA1 Acknowledgment is a means of replying to an interchange or transmission that has been sent. The TA1 verifies the envelopes only. Transaction set-specific verification is accomplished through use of the Functional Acknowledgment Transaction Set, 997. The TA1 is a single segment and is unique in the sense that this single segment is transmitted without the GS/GE envelope structures. A TA1 can be included in an interchange with other functional groups and transactions. Trading partners shall follow the Interchange Control Structure (ICS), Functional Group Structure (GS), Interchange Acknowledgment (TA1), and Functional Acknowledgement (997) guidelines for HIPAA that are located in the HIPAA Implementation Guides in Appendix A and B.
Taxonomy codes	These are national specialty codes used by providers to indicate their specialty at the claim level.
Trading Partners	Covered entities who are involved in Electronic Data Interchange involving HIPAA ANSI transactions.

Utilization Management (UM)	Refers to the process to evaluate the medical necessity, appropriateness, and efficiency of the use of health care services, procedures, and facilities. UM is inclusive of utilization review and service authorization.
Validation	The review of information, data, and procedures to determine the extent to which data is accurate, reliable, free from bias and in accord with standards for data collection and analysis.
Will	Denotes a mandatory requirement.

Appendix B

Frequently Asked Questions (FAQs)

What is HIPAA and how does it pertain to the SMO?

The Administrative Simplification provisions of HIPAA, Title II, include requirements that national standards be established for electronic health care transactions. These standards are being adopted to improve the efficiency and effectiveness of the nation's health care system by encouraging the widespread use of EDI in health care. DHH has chosen to adopt these standards for SMO encounter data reporting.

What is Molina and what is their role with the SMO?

Molina is under contract as DHH's Fiscal Intermediary and responsible for providing functions and services to receive and send ANSI ASC X12N transactions on behalf of their clients.

Is there more than one 837 format? Which shall I use?

There are three HIPAA-compliant 837 transactions — Institutional, Professional, and Dental services. The transactions the SMO will use will depend upon the type of service being reported. Further instructions can be found in Section 2 of this Guide.

Whom do I contact if I have a question regarding the EDI Information Sheet or need technical assistance concerning electronic claim submission?

You may contact the Molina EDI Support Unit Monday through Friday, from 8:00 a.m. to 5:00 p.m. CDT, at 225-216-6303.

I am preparing for testing with EDIFECS. Whom do I contact for more information?

For answers to questions regarding specifications and testing, please contact Molina's EDI Business Support Analysts at 225-216-6303.

Will DHH provide us with a paper or electronic remittance advice?
DHH's FI will provide the SMO with an electronic 835 Health Care Claim Payment/Advice (ERA), if requested and arranged in advance.

Where can I find HIPAA code lists, including the Claim Adjustment Reason Codes and Remittance Remark Codes, which appear in the 835 Health Care Claim?

The Claim Adjustment Reason Codes provide the "explanation" for the positive or negative financial adjustments specific to particular claims or services that are referenced in the 835.

The Remittance Remark Codes are used in the 835 to relay informational messages that cannot be expressed with a Claim Adjustment Reason Code. These codes are all nationally mandated codes that must be used by payers in conjunction with the 835.

Payers may no longer use the proprietary codes that they used prior to HIPAA, even if the proprietary codes give better details about how a claim was adjudicated.

HIPAA code lists can be found on the Washington Publishing Company's website at: http://www.wpc-edi.com/codes/.

We understand that DHH will require the NPI, taxonomy code and 9-digit zip of the provider to process the 837 COB. Is this correct?

Yes, that is correct. Effective with claims and encounter submissions after May 23, 2008, all providers are required to have an NPI and taxonomy. DHH will also require that a 9-digit zip code be placed on the encounter.

Does Molina have any payer-specific instructions for 837 COB transactions?

Yes, the Molina Companion Guides contain a number of payer-specific instructions for 837 transactions. The FI Companion Guides can be found at www.lamedicaid.com. Once on the DHH website, choose HIPAA Billing Instructions & Companion Guides from the left hand menu. There are separate companion guides for each of the 837 transactions.

What is a Trading Partner ID?

The Trading Partner ID is a number assigned by the FI for each submitter of encounter data. You are assigned this ID prior to testing.

Why must the SMO submit encounter data?

The reasons why the SMO is required to submit encounter data are as follows:

1. Encounter Data: Section 17.5.4 of the SMO RFP details the requirements for encounter submission.

2. Rate Setting: The BBA requires the use of base utilization and cost data that is derived from the Medicaid population in order to produce actuarially sound capitation rates. Rates are considered actuarially sound if they are appropriate for the covered Medicaid population and the services that are provided under the Contract.

3. Utilization Review and Clinical Quality Improvement: The LABHP is partially funded by CMS. Encounter data is analyzed and used by CMS and DHH-OBH to evaluate program effectiveness and monitor quality of care, utilization levels and patterns, access to care, and to evaluate SMO performance. The utilization data from encounter data provides DHH with performance data and indicators. DHH-OBH will use this information to evaluate the performance of the SMO and to audit the validity and accuracy of the reported measures.
4. Payment for children's services: The LABHP will not be paid for children's invoices not substantiated by encounter data and supporting the non-risk payment per 42 CFR 447.362 and containing the elements required for a minimum Medicaid claim to CMS per State Medicaid Manual 2497.

Appendix C

Code Sets

The use of standard code sets will improve the effectiveness and efficiency of Medicaid, Federal, and other private health programs through system administration simplification and efficient electronic transmission of certain health information. *Code set* means any set of codes used to encode data elements, such as tables of terms, medical concepts, medical diagnostic codes, or medical procedure codes. A code set includes the codes and the descriptors of the codes.

When conducting 837 transactions, DHH requires the SMO to adhere to HIPAA standards governing Medical data code sets. Specifically, the SMO must use the applicable medical data code sets described in §162.1002, as specified in the IGs that are valid at the time the health care is furnished. The SMO is also required to use the non-medical data code sets, as described in the IGs that are valid at the time the transaction is initiated.

DHH requires the SMO to adopt the following standards for Medical code sets and/or their successor code sets:

A. International Classification of Diseases, 9th Edition, Clinical Modification (ICD-9-CM), Volumes 1 and 2 (including The Official ICD-9-CM Guidelines for Coding and Reporting), as maintained and distributed by DHHS, for the following conditions:

- Diseases;
- Injuries;
- Impairments;
- Other health problems and their manifestations; and
- Causes of injury, disease, impairment, or other health problems.

B. ICD-9-CM, Volume 3 Procedures (including The Official ICD-9-CM Guidelines for Coding and Reporting), as maintained and distributed by DHHS, for the following procedures or other actions taken for diseases, injuries, and impairments on inpatients reported by hospitals:
   - Prevention;
   - Diagnosis;
   - Treatment; and
   - Management.

C. National Drug Codes (NDC), as maintained and distributed by DHHS, in collaboration with drug manufacturers, for the following:

   - Drugs; and
   - Biologics.

D. Current Dental Terminology (CDT) Code on Dental Procedures and Nomenclature, as maintained and distributed by the American Dental Association (ADA) for dental services.

E. The combination of Health Care Financing Administration Common Procedure Coding System (HCPCS), as maintained and distributed by HHS, and Current Procedural Terminology, Fourth Edition (CPT-4), as maintained and distributed by the American Medical Association (AMA), for physician services and other health care services. Category I CPT codes describe a procedure or service identified with a five-digit CPT code and descriptor nomenclature. The inclusion of a descriptor and its associated specific five-digit identifying G-code number in this category of CPT codes is generally based upon the procedure being consistent with contemporary medical practice and being performed by many physicians in clinical practice in multiple locations. Services described by Category I CPT codes include, but are not limited to, the following:

   - The services manual outlined in the SMO contract,
   - Physician services,
   - Physical and occupational therapy services,
   - Radiological procedures,
   - Clinical laboratory tests,
   - Other medical diagnostic procedures

   In addition to the Category I codes described above, DHH requires that the SMO submit CPT Category II codes. CPT Category II codes are supplemental tracking G-codes that can be used for performance measurement. The use of the tracking G-codes for performance measurement will decrease the need for record abstraction and chart review, and thereby minimize administrative burdens on physicians and other health care professionals. These codes are intended to facilitate data collection

about quality of care by coding certain services and/or test results that support performance measures and that have been agreed upon as contributing to good patient care. Some codes in this category may relate to compliance by the health care professional with state or federal law.

F. The HCPCS, as maintained and distributed by DHHS, for all other substances, equipment, supplies, or other items used in health care services. These items include, but are not limited to, the following:

- Medical supplies,
- Orthotic and prosthetic devices, and
- Durable medical equipment.
- Other services, as applicable, in the manual outlined in the SMO contract

Appendix D

System Generated Reports

The over arching purpose of this set of reports is to enhance the quality of the encounter data by providing DHH-OBH and the SMO with a basic accuracy and completeness assessment of each claim after each encounter cycle in order that preliminary corrections and repairs can be conducted and the encounter resubmitted to the FI. These reports will take advantage of the existing MMIS reporting capacity for claims data. However, the reports are altered, as necessary, to enhance their usefulness in depicting encounter data errors.

Encounter data is submitted through the FI's Electronic Data Interchange (EDI) and undergoes a series of 837 COB edits, passing through to the MMIS, and then going through a set of edits that will result in summary and repairable edit codes reports and a summary report of the encounter data submitted. These edit codes are listed in Appendix D of this Guide. Those edit codes that assess encounters to be repairable for correction and resubmission by the SMO are found in Section 6 of this Guide.

The following reports are generated by the MMIS system and have been selected specifically to provide the SMO with useful information that, when compared with the 835 Remittance Advice for the specific encounter, will provide a complete explanation for the edit code. A second set of reports that focus more closely on the overall quality of the data will also be created from the encounter data. These quality reports will also depict accuracy and completeness at a volume and utilization level.

ASC X12N 835

As discussed above, and in Section 5, the SMO will receive an 835 for encounter data that has been processed through the MMIS if requested and arranged in advance. Adjustment reason code, adjustment amount, and adjustment quantity are returned via

the CAS segment of loop 2110 if the service line fails MMIS encounter errors. CAS segments are also created for cutbacks to the submitted charge-for-fee schedule reductions, etc. All encounter data denials, including those that are repairable, are represented in the 835. TCNs are assigned by claim and can be located in the 835 specific to the encounter.

820 File (FI to SMO)

See below.

Loop	Segment	Field	Description	Valuation	Derived Value (D), Column Map (M), Static Value (S)
ST=Transaction Set Header					
Sample: ST*820*0001*005010X218~					
	ST	ST01	Transaction Set Identifier Code	'820'	S
Remark: The transaction set control numbers in ST02 and SE02 must be identical. This number must be unique within a specific group and interchange, but the number can repeat in other groups and interchanges.					
		ST02	Transaction Set Control Number		
Remark: Identifying control number that must be unique within the transaction set functional group assigned by the originator for a transaction set. The Transaction Set Control Number in ST02 and SE02 must be identical. The number must be unique within a specific interchange (ISA-IEA), but can repeat in other interchanges.					
		ST03	Implementation Convention Reference	'005010X218'	S
Remark: This element must be populated with the guide identifier named in Section 1.2 of the IG. The unique Version/Release/Industry Identifier Code for transaction sets that are defined by this implementation guide is 005010X218. This field contains the same value as GS08. Some translator products strip off the ISA and GS segments prior to application (STSE) processing. Providing the information from the GS08 at this level will ensure that the appropriate application mapping is utilized at translation time.					
BPR=Financial Information					
Sample: BPR*I*950.00*C*NON******1726011595******20120209~					
	BPR	BPR01	Transaction Handling Code	I=Remittance Information Only	S
		BPR02	Monetary Amount	Total Premium Payment Amount	D
		BPR03	Credit/Debit Flag Code	C=Credit	S
		BPR04	Payment Method Code	NON	S
		BPR05	Payment Format Code	NOT USED	S
		BPR06	(DFI) ID Number Qualifier	NOT USED	S

Loop	Segment	Field	Description	Valuation	Derived Value (D), Column Map (M), Static Value (S)
Remark: Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier. SEMANTIC: BGN06 is the transaction set reference number of a previously sent transaction affected by the current transaction. SITUATIONAL RULE: Required when there is a previously sent transaction to cross-reference. If not required by this implementation guide, do not send.					
		BPR07	(DFI) Identification Number	NOT USED	S
		BPR08	Account Number Qualifier	NOT USED	S
		BPR09	Account Number		S
		BPR10	Originating Company Identifier	Federal tax ID number preceded by a 1.	S
		BPR11	Originating Company Supplemental Code	NOT USED	
		BRP12	(DFI) ID Number Qualifier	NOT USED	S
		BPR13	(DFI) Identification Number	NOT USED	S
		BRP14	Account Number Qualifier	NOT USED	S
		BPR15	Account Number		
		BPR16	EFT Effective Date	Expressed CCYYMMDD	
TRN=Reassociation Trace Number					
Sample: TRN*3*1123456789**~					
	TRN	TRN01	Trace Type Code	"3" – Financial Reassociation Trace Number. The payment and remittance information have been separated and need to be reassociated by the receiver.	S
		TRN02	Reference Identification	EFT Trace Number Used to reassociate payment with remittance information.	S
		TRN03	Originating Company Identifier	Must contain the Federal Tax ID number preceded by a 1 and must be identical to BPR10	S
REF=Premium Receiver's Identification Key					
Sample: REF*18*123456789*SMO Fee Payment~					

Loop	Segment	Field	Description	Valuation	Derived Value (D), Column Map (M), Static Value (S)
		REF01	Reference Identification Qualifier	'18'=Plan Number	S
		REF02	Reference Identification	Premium Receiver Reference Identifier	
		REF03	Description	'SMO Fee Payment'	S
DTM=Process Date					
Sample: DTM*009*20120103~					
		DTM01	Date/Time Qualifier	"009" – Process	S
		DTM02	Date	Payer Process Date CCYYMMDD	S
DTM=Delivery Date					
Sample: DTM*035*20120103~					
		DTM01	Date/Time Qualifier	"035" – Delivered	S
		DTM02	Date	Payer Process Date CCYYMMDD	S
DTM=Report Period					
Sample: DTM*582****RD8*20120101-20120131~					
		DTM01	Date/Time Qualifier	"582" – Report Period	S
		DTM02	Not Used	Not Used	
		DTM03	Not Used	Not Used	
		DTM04	Not Used	Not Used	
		DTM05	Date Time Period Qualifier	'RD8'	S
		DTM06	Date Time Period	Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD	D
1000A PREMIUM RECEIVER'S NAME					
N1=Premium Receiver's Name					
Sample: N1*PE*SMO of Louisiana*FI*1123456789~					
	1000A	N101	Entity ID Code	"PE" – Payee	
	1000A	N102	Name	Information Receiver Last or Organization Name	
	1000A	N103	Identification Code Qualifier	"FI" – Federal	

Loop	Segment	Field	Description	Valuation	Derived Value (D), Column Map (M), Static Value (S)
	1000A	N104	Identification Code	Receiver Identifier	
1000B PREMIUM PAYER'S NAME					
N1=Premium Payer's Name					
Sample: N1*PR*Louisiana Department of Health and Hospitals*FI*1123456789~					
	1000B	N101	Entity ID Code	"PR" – Payer	
	1000B	N102	Name	Premium Payer Name	
	1000B	N103	ID Code Qualifier	"FI" - Federal Taxpayer ID number	
	1000B	N104	Identification Code	Premium Payer ID	
2000B INDIVIDUAL REMITTANCE					
ENT=Individual Remittance					
Sample: ENT*1*2J*34*123456789~					
	2000B	ENT01	Assigned Number	Sequential Number assigned for differentiation within a transaction set	
	2000B	ENT02	Entity Identifier Code	"2J" - Individual	
	2000B	ENT03	Identification Code Qualifier	"34" - Social Security Number	
	2000B	ENT04	Identification Code	Individual Identifier - SSN	
2100B INDIVIDUAL NAME					
NM1=Policyholder Name					
Sample: NM1*QE*1*DOE*JOHN*Q***N*1234567890123~					
	2100B	NM101	Entity Identifier Code	"QE" - Policyholder (Recipient Name)	
	2100B	NM102	Policyholder	"1" - Person	
	2100B	NM103	Name Last	Individual Last Name	
	2100B	NM104	Name First	Individual First Name	
	2100B	NM105	Name Middle	Individual Middle Initial	
	2100B	NM106	NOT USED	NOT USED	
	2100B	NM107	NOT USED	NOT USED	

Loop	Segment	Field	Description	Valuation	Derived Value (D), Column Map (M), Static Value (S)
	2100B	NM108	Identification Code Qualifier	"N" – Insurer's Unique ID number	
	2100B	NM109	Identification Code	Recipient ID	
2300B INDIVIDUAL PREMIUM REMITTANCE DETAIL					
RMR=Organization Summary Remittance Detail					
Sample: RMR*AZ*1234567890123**400.00~					
	2300B	RMR01	Reference Identification Qualifier	"11" - Account Number	
	2300B	RMR02	Reference Identification	Claim ICN	
	2300B	RMR04	Monetary Amount	Detail Premium Payment Amount	
REF=Reference Information					
Sample: REF*ZZ*0101C~					
	2300B	REF01	Reference Identification Qualifier	"ZZ" - Mutually Identified	
	2300B	REF02	Reference Identification	Capitation Code	
	2300B	REF03	Not Used		
	2300B	REF04	Not Used		
DTM=Individual Coverage Period					
Sample: DTM*582****RD8*20120101-20120131~					
	2300B	DTM01	Date/Time Qualifier	"582" - Report Period	
	2300B	DTM02	NOT USED	NOT USED	
	2300B	DTM03	NOT USED	NOT USED	
	2300B	DTM04	NOT USED	NOT USED	
	2300B	DTM05	Date Time Period Format Qualifier	"RD8" – Range of Dates	
	2300B	DTM06	Date Time Period	Coverage Period, expressed as CCYYMMDD-CCYYMMDD	
Transaction Set Trailer					
Sample: SE*39*0001~					

Loop	Segment	Field	Description	Valuation	Derived Value (D), Column Map (M), Static Value (S)
	SE	SE01	Transaction Segment Count		
		SE02	Transaction Set Control Number		
Remark: The transaction set control numbers in ST02 and SE02 must be identical. This number must be unique within a specific group and interchange, but the number can repeat in other groups and interchanges.					

Encounter Claims Summary — Molina Report (FI to SMO)
SMO-O-001 (initial) and SMO-W-001 (weekly)

NOTE: This report has been replaced by the Weekly Claims/Encounters File that is being sent to Magellan via the File Exchange established in January and February 2012.

This report will NOT be issued.

This report will serve as the high-level error report for the SMO as a summarization of the errors incurred. The format, as depicted below, is by claim type. This report **will be distributed as a delimited text file** and it will produce the overall claim count with the disposition of MMIS paid or denied status occurrence and overall percentage. The number and percent to be denied represent all denials, repairable or not.

Column(s)	Item	Notes	Length	Format
HEADER RECORD		There is only one header record per file.		
1	Record Type	0=Header	1	Numeric
2	Delimiter		1	Uses the ^ character value
3-12	Report ID	Value is “SMO-W-001” or “SMO-O-001”	10	Character
13	Delimiter		1	Uses the ^ character value
14-21	Report Date	Date that the report was created by Molina.	8	Numeric, format YYYYMMDD
22	Delimiter		1	Uses the ^ character value
23-72	Report Description	Value is “Claims Summary”	50	Character
73	Delimiter		1	Uses the ^ character value
74-80	SMO Provider ID	Medicaid Provider ID associated with	7	Numeric

Column(s)	Item	Notes	Length	Format
		the SMO.		
81	Delimiter		1	Uses the ^ character value
DETAIL RECORD		There may be multiple detail records per file.		
1	Record Type	1=Detail	1	Numeric
2	Delimiter		1	Uses the ^ character value
3-12	Report ID	Value is “SMO-W-001” or “SMO-O-001”	10	Character
13	Delimiter		1	Uses the ^ character value
14-21	Detail Line Number	The line number of the detail record. The detail portion of the file is sorted by this number	8	Numeric
22	Delimiter		1	Uses the ^ character value
23-24	Claim Type	Will have one of these values: 01=Inpatient 02=LTC/NH 03=Outpatient 04=Professional 05=Rehab 06=Home Health Outpatient 07=Emergency Medical Transportation 08=Non-emergency Medical Transportation 09=DME 10=Dental 11=Dental 12=Pharmacy 13=EPSDT Services. 14=Medicare Crossover Instit. 15=Medicare Crossover Prof	2	Numeric
25	Delimiter		1	Uses the ^ character value

Column(s)	Item	Notes	Length	Format
26-33	Number of claim records accepted		8	Numeric, no commas, decimal points.
34	Delimiter		1	Uses the ^ character value
35-42	Number of claim records denied		8	Numeric, no commas, decimal points.
43	Delimiter		1	Uses the ^ character value
44-51	Percentage of Denied Claims		8	Numeric, with decimal point. For example, 00015.99 represents 15.99%
52	Delimiter		1	Uses the ^ character value
53-81	End of Record		29	Value is spaces.
TRAILER (TOTALS) RECORD		There is only one trailer record per file.		
1	Record Type	9=Trailer	1	Character
2	Delimiter		1	Uses the ^ character value
3-12	Report ID	Value is “SMO-W-001” or “SMO-O-001”	10	Character
13	Delimiter		1	Uses the ^ character value
14-21	Not Used		8	Character value is spaces.
22	Delimiter		1	Uses the ^ character value
23-24	Totals Line Indicator		2	Numeric, value is 99.
25	Delimiter		1	Uses the ^ character value
26-33	Total Number of Claim records accepted		8	Numeric, no commas, decimal points.
34	Delimiter		1	Uses the ^ character value
35-42	Total Number		8	Numeric, no

Column(s)	Item	Notes	Length	Format
	of Claim records denied			commas, decimal points.
43	Delimiter		1	Uses the ^ character value
44-51	Overall Percentage of Denied Claims		8	Numeric, with decimal point. For example, 00015.99 represents 15.99%
52	Delimiter		1	Uses the ^ character value
53-81	End of Record		29	Value is spaces.

Encounter Edit Disposition Summary — Molina Report (FI to SMO)
SMO-O-005 (initial) and SMO-W-005 (weekly)

NOTE: This report has been replaced by the Weekly Claims/Encounters File that is being sent to Magellan via the File Exchange established in January and February 2012.

This report will NOT be issued.

This report will serve as the high-level edit report for the SMO as a summarization of the edit codes incurred. The format, as depicted below, is by claim type. This report **will be distributed as a delimited text file** and it will produce the overall edit code disposition, edit code, and the number of edit codes from the submission.

Column(s)	Item	Notes	Length	Format
HEADER RECORD		There is only one header record per file.		
1	Record Type	0=Header	1	Numeric
2	Delimiter		1	Uses the ^ character value
3-12	Report ID	Value is “SMO-W-005” or “SMO-O-005”	10	Character
13	Delimiter		1	Uses the ^ character value
14-21	Report Date	Date that the report was created by Molina.	8	Numeric, format YYYYMMDD
22	Delimiter		1	Uses the ^ character value
23-72	Report Description	Value is “EDIT Disposition Summary”	50	Character
73	Delimiter		1	Uses the ^ character value
74-80	SMO Provider ID	Medicaid Provider ID associated with the SMO.	7	Numeric
81	Delimiter		1	Uses the ^ character value
DETAIL RECORD		There may be multiple detail records per file.		

Column(s)	Item	Notes	Length	Format
1	Record Type	1=Detail	1	Numeric
2	Delimiter		1	Uses the ^ character value
3-12	Report ID	Value is “SMO-W-005” or “SMO-O-005”	10	Character
13	Delimiter		1	Uses the ^ character value
14-21	Detail Line Number	The line number of the detail record. The detail portion of the file is sorted by this number.	8	Numeric
22	Delimiter		1	Uses the ^ character value
23-24	Claim Type	Will have one of these values: 01=Inpatient 02=LTC/NH 03=Outpatient 04=Professional 05=Rehab 06=Home Health Outpatient 07=Emergency Medical Transportation 08=Non-emergency Medical Transportation 09=DME 10=Dental 11=Dental 12=Pharmacy 13=EPSDT Services 14=Medicare Crossover Instit. 15=Medicare Crossover Prof.	2	Numeric
25	Delimiter		1	Uses the ^ character value
26-29	Error Code		4	Numeric
30	Delimiter		1	Uses the ^ character value
31-38	Number of claim records having this error code		8	Numeric
39	Delimiter		1	Uses the ^ character value

Column(s)	Item	Notes	Length	Format
40-81	End of Record		42	Value is spaces.
TRAILER (TOTALS) RECORD		There is only one trailer record per file.		
1	Record Type	9=Trailer	1	Numeric
2	Delimiter		1	Uses the ^ character value
3-12	Report ID	Value is “SMO-W-005” or “SMO-O-005”	10	Character
13	Delimiter		1	Uses the ^ character value
14-21	Total Detail Lines in the file	This is a number that represents the total detail lines submitted in the file.	8	Numeric
22	Delimiter		1	Uses the ^ character value
23-24	Totals Line Indicator		2	Numeric, value is 99.
25	Delimiter		1	Uses the ^ character value
26-29	Unused		4	Value is spaces
30	Delimiter		1	Uses the ^ character value
31-38	Total Number of Claim records denied	This value should match that of the SMO-W-001 or SMO-O-001 file. It may not equal the total of all detail lines in the SMO-W-005 or SMO-O-005 file because one claim may have several edits.	8	Numeric
39	Delimiter		1	Uses the ^ character value
40-81	End of Record		42	Value is spaces.

Edit Code Detail — Molina Report (FI to SMO)
SMO-O-010 (initial) and SMO-W-010 (weekly)

NOTE: This report has been replaced by the Weekly Claims/Encounters File that is being sent to Magellan via the File Exchange established in January and February 2012.

This report will NOT be issued.

This report lists encounters all encounters and their error codes, including denied error codes. Some of the denied edits are repairable. Refer to Section 3 of the Guide for a listing of repairable edits. **This report will be distributed as a delimited text file** and it is a detailed listing by header and line item of the edits applied to the encounter data.

Column(s)	Item	Notes	Length	Format
HEADER RECORD		There is only one header record per file.		
1	Record Type	0=Header	1	Numeric
2	Delimiter		1	Uses the ^ character value
3-12	Report ID	Value is “SMO-W-010” or “SMO-O-010”	10	Character
13	Delimiter		1	Uses the ^ character value
14-21	Report Date	Date that the report was created by Molina.	8	Numeric, format YYYYMMDD
22	Delimiter		1	Uses the ^ character value
23-72	Report Description	Value is “Claim Detail”	50	Character
73	Delimiter		1	Uses the ^ character value
74-80	SMO Provider ID	Medicaid Provider ID associated with the SMO.	7	Numeric
81	Delimiter		1	Uses the ^ character value
82	End of Record		1	Value is spaces.
DETAIL		There may be		

Column(s)	Item	Notes	Length	Format
RECORD		multiple detail records per file.		
1	Record Type	1=Detail	1	Numeric
2	Delimiter		1	Uses the ^ character value
3-12	Report ID	Value is “SMO-W-010” or “SMO-O-010”	10	Character
13	Delimiter		1	Uses the ^ character value
14-21	Detail Line Number	The line number of the detail record. The detail portion of the file is sorted by this number	8	Numeric
22	Delimiter		1	Uses the ^ character value
23-35	Claim ICN	Internal Claim Number, assigned by Molina. Unique per claim line.	13	Numeric
36	Delimiter		1	Uses the ^ character value
37-66	Medical Record Number	Submitted on the claim by the SMO.	30	Character
67	Delimiter		1	Uses the ^ character value
68-87	Patient Control Number	Submitted on the claim by the SMO	20	Character
88	Delimiter		1	Uses the ^ character value
89-118	Line Control Number	Submitted on the claim by the SMO	30	Character
119	Delimiter		1	Uses the ^ character value
120-128	Remittance Advice	Assigned by	9	Numeric

Column(s)	Item Number	Notes Molina	Length	Format
129	Delimiter		1	Uses the ^ character value
130-133	Error Code 1	First error code, if claim was denied.	4	Numeric
134	Delimiter		1	Uses the ^ character value
135-138	Error Code 2 (if necessary)	2nd error code, if claim was denied and if available.	4	Numeric
139	Delimiter		1	Uses the ^ character value
140-143	Error Code 3 (if necessary)	3rd error code, if claim was denied and if available.	4	Numeric
144	Delimiter		1	Uses the ^ character value
145-148	Error Code 4 (if necessary)	4th error code, if claim was denied and if available.	4	Numeric
149	Delimiter		1	Uses the ^ character value
150-153	Error Code 5 (if necessary)	5th error code, if claim was denied and if available.	4	Numeric
154	Delimiter		1	Uses the ^ character value
155-158	Error Code 6 (if necessary)	6th error code, if claim was denied and if available.	4	Numeric
159	Delimiter		1	Uses the ^ character value
160-163	Error Code 7 (if necessary)	7th error code, if claim was denied	4	Numeric

Column(s)	Item	Notes	Length	Format
		and if available.		
164	Delimiter		1	Uses the ^ character value
165-168	Error Code 8 (if necessary)	8th error code, if claim was denied and if available.	4	Numeric
169	Delimiter		1	Uses the ^ character value
170-173	Error Code 9 (if necessary)	9th error code, if claim was denied and if available.		
174	Delimiter		1	Uses the ^ character value
175-178	Error Code 10 (if necessary)	10th error code, if claim was denied and if available.		
179	Delimiter		1	Uses the ^ character value
180	Type of Admission		1	Character
181	Delimiter		1	Uses the ^ character value
182-191	Medicaid Paid Units		10	Numeric with decimal point, left zero-fill.
192	Delimiter		1	Uses the ^ character value.
193-195	Patient Status		3	Character
196	Delimiter		1	Uses the ^ character value.
197-204	DOS-From		8	Numeric, YYYYMMDD
205	Delimiter		1	Uses the ^ character value.
206-213	DOS-Through		8	Numeric, YYYYMMDD
214	Delimiter		1	Uses the ^ character value.
215-227	Medicaid Recipient ID	Recipient's current	13	Character

Column(s)	Item	Notes	Length	Format
		Medicaid ID number		
228	Delimiter		1	Uses the ^ character value.
229-242	Provider Billed Charges	Billed charges from provider as submitted by Provider on claim	14	Numeric with decimal point, left zero-fill.
243	Delimiter		1	Uses the ^ character value.
244-248	Procedure Code	As submitted by Provider on claim, for all claim types except inpatient hospital.		Character
249	Delimiter		1	Uses the ^ character value.
250-259	Provider Billed Units	As submitted by Provider on claim	10	Numeric with decimal point, left zero-fill.
260	Delimiter		1	Uses the ^ character value.
261-274	Medicaid Payment	Amount Louisiana Medicaid paid on the claim	14	Numeric with decimal point, left zero-fill.
275	Delimiter		1	Uses the ^ character value.
276-286	NDC	If Rx claim, then this is the NDC on the claim	11	
287	Delimiter		1	Uses the ^ character value.
288-290	Therapeutic Class	If Rx claim	3	
291	Delimiter		1	Uses the ^ character value.
292	Rx refill code	If Rx claim: 0=1st script, 1-5=refill number	1	
293	Delimiter		1	Uses the ^ character value.

Column(s)	Item	Notes	Length	Format
294-298	Diagnosis Code	ICD-9-CM diag code, if available	5	Character, does not include the decimal.
299	Delimiter		1	Uses the ^ character value.
300	Admit Date		8	Numeric, YYYYMMDD For inpatient hospital claims
308	Delimiter		1	Uses the ^ character value.
309-316	Discharge Date		8	Numeric, YYYYMMDD For inpatient hospital claims
317	Delimiter		1	Uses the ^ character value.
318-319	Servicing Provider Specialty		2	Numeric with leading zero if necessary.
320	Delimiter		1	Uses the ^ character value.
321-330	Prior Authorization Number		10	Numeric, 9 or 10 digits
331	Delimiter		1	Uses the ^ character value.
332-334	Bill Type		3	Claim Bill Type (inpatient and institutional)
335	Delimiter		1	Uses the ^ character value.
336-337	Type of Service		2	See Type of Service values in Appendix H
338	Delimiter		1	Uses the ^ character value.
339-340	Category of Service		2	See Category of Service values in Appendix H
341	Delimiter		1	Uses the ^ character value.

Column(s)	Item	Notes	Length	Format
342-351	Billing Provider NPI		10	
352	Delimiter		1	Uses the ^ character value.
353-362	Servicing/ Attending Provider NPI		10	
363	Delimiter		1	Uses the ^ character value.
364-365	Billing Provider Type		2	See Provider Type values in Appendix H
366	Delimiter		1	Uses the ^ character value.
367-368	Servicing/ Attending Provider Type		2	See Provider Type values in Appendix H
369	Delimiter		1	Uses the ^ character value.
370	Claim Status		1	Numeric: 1=Paid Original 2=Adjustment/Void 3=Denied
371	Delimiter		1	Uses the ^ character value.
372	Claim Status Modifier		1	Numeric: 1=Paid Original 2=Adjustment 3=Void (for adjustment) 4=Void (from provider)
373	Delimiter		1	Uses the ^ character value.
374	Claim Type		2	01=Inpatient Hosp 02=LTC/ICF/NH 03=Outpatient Hosp 04=Professional 05=Rehab 06=Home Health 07=EMT 08=NEMT 09=DME 10=Dental EPSDT 11=Dental Adult 12=Pharmacy 13=EPSDT 14=Medicare Institutional Crossover

Column(s)	Item	Notes	Length	Format
				15=Medicare Professional Crossover 16=ADHC
376	Delimiter		1	Uses the ^ character value.
377	Not populated		4	Spaces.
381	Delimiter		1	Uses the ^ character value.
382-383	Procedure Modifier 1		2	Character
384	Delimiter		1	Uses the ^ character value.
385-386	Procedure Modifier 2		2	Character
387	Delimiter		1	Uses the ^ character value.
388-389	Procedure Modifier 3		2	Character
390	Delimiter		1	Uses the ^ character value.
The following items represent revenue codes, HCPCS, units and charges associated with institutional claims. There are 23 occurrences.				
391-394	Revenue Code 1		4	Numeric
395	Delimiter		1	Uses the ^ character value.
396-400	Revenue HCPCS 1		5	Character
401	Delimiter		1	Uses the ^ character value.
402-406	Revenue Units 1		5	Numeric
407	Delimiter		1	Uses the ^ character value.
408-421	Revenue Charges 1		14	Numeric with decimal point, left zero-fill.
422	Delimiter		1	Uses the ^ character value.
There are 23 occurrences of the revenue items, with each occurrence being 32 bytes in length (consisting of code, HCPCS, Units and Charges, with delimiters).				
1127	Claim Payment		8	Numeric data

Column(s)	Item	Notes	Length	Format
	Date			format in the format YYYYMMDD
1135	End of Record		1	Character, value is space.
TRAILER (TOTALS) RECORD		There is only one trailer record per file.		
1	Record Type	9=Trailer	1	Numeric
2	Delimiter		1	Uses the ^ character value
3-12	Report ID	Value is “SMO-W-010” or “SMO-O-010”	10	Character
13	Delimiter		1	Uses the ^ character value
14-21	Total Detail Lines in the file	This is a number that represents the total detail lines submitted in the file. It is equivalent to the total number of claim lines that denied.	8	Numeric
22	Delimiter		1	Uses the ^ character value
23-24	Totals Line Indicator		2	Numeric, value is 99.
25	Delimiter		1	Uses the ^ character value
26-33	Total Number of claim records denied.	This value represents the count of unique claim lines that appear in the detail portion of this file and have been denied.	8	Numeric

Column(s)	Item	Notes	Length	Format
34	Delimiter		1	Uses the ^ character value
35	End of Record		1	Value is space.

Appendix E

SMO Generated Reports

The over arching purpose of this set of reports is to supplement information that is reported through the encounter process. Once the encounter process has stabilized, DHH may use encounters as the basis for these reports.

Denied Claims Report

DHH-OBH is interested in analyzing claims that are denied for the following reasons:

1. Lack of documentation to support Medical Necessity
2. Prior Authorization was not on file
3. Member has other insurance that must be billed first
4. Claim was submitted after the filing deadline
5. Service was not covered by the SMO

In the future, DHH may elect to obtain additional denied claims information.

In the interim, the SMO is to submit to DHH-OBH an electronic report monthly on the number and type of denied claims referenced above. The report shall include:

- Denial reason code including long description
- Claim type
- Missing documentation to support medical necessity
- Missing documentation of prior authorization (PA); e.g. no PA on file
- Date of service
- Date of receipt by SMO
- Primary diagnosis
- Secondary diagnosis (if applicable)

- Procedure/HCPCS code(s)
- Surgical procedure code(s) (if applicable)
- Revenue code(s) (if applicable)
- Primary insurance carrier (if applicable)
- Primary insurance coverage begin date (if applicable)

FQHC and RHC Quarterly Report

The SMO shall submit on a quarterly basis by date of service, a report of encounter/claim data of all contracting FQHCs and RHCs for State Plan required reconciliation purposes. The report shall include the following information:

- Name and NPI of Rendering Provider
- Name and NPI of Billing Provider
- Medicaid ID of recipient
- Date of Service
- Paid Date
- Billed Amount
- Paid Amount

Appendix F

Encounter Edit Codes

In order for data to be useful, the data must meet minimum thresholds of data quality. One of the most basic tests of data quality is editing. All encounter data submitted to the MMIS are subject to edits. Edits may post at the line or at the header. If an encounter denies at the header the encounter must be corrected and resubmitted. Instructions for correcting line level denials are found in Section 7 of this Guide.

Encounter data edits can have one of the following dispositions:

- Encounter passes all edits and is accepted into the MMIS and priced, per DHH guidelines (Pay),
- Encounter contains a fatal error that results in its rejection (Denial).

Below are tables for encounters set to information only (pay) and non-repairable denials. Please see Section 3 of this Guide for the edit codes that are repairable denials and instructions for correction and resubmission by the SMO.

EDIT CODE	EDIT DISPOSITION – INFORMATION ONLY (E) EDIT DESCRIPTION
029	SERVICE MORE THAN 12 MONTHS OLD
030	SERVICE THRU DATE TOO OLD
084	TREATMENT PLACE INVALID
108	PROVIDER TYPE SERVICES NOT COVERED FOR RECIPIENT AGE
142	BILLING PROVIDER NPI MISSING/NOT ON FILE
143	SERVING PROVIDER NPI MISSING/NOT ON FILE
145	BILLING PROVIDER NPI MISMATCH

EDIT CODE	EDIT DISPOSITION – INFORMATION ONLY (E) EDIT DESCRIPTION
146	SERVICING PROVIDER NPI MISMATCH
201	PROVIDER NOT ELIGIBLE ON DATES OF SERVICE
207	BILLING PROVIDER INELIGIBLE ON DATE OF SERVICE
272	CLAIM EXCEEDS 1 YEAR FILING LIMIT
279	INVALID PLACE OF TREATMENT FOR PROF COMP
294	RECIPIENT NOT ON FILE RECYCLED 3 TIMES
295	RECIPIENT INELIGIBLE RECYCLED THREE TIMES
297	DECLARED BANKRUPTCY.FILE W/CARRIER FOR POSSIBLE PMTS.
330	QUALIFIED MEDICARE BENEFICIARY NOT MEDICAID ELIGIBLE
427	PSYCHIATRIC SERVICES NOT COVERED UNDER HOME HEALTH
546	Code added due to a REB of a current code only
550	MULTIPLE PROVIDERS WILL NOT BE PAID FOR THIS PROCEDURE
556	ATTENDING/SERVICING PROVIDER IS NOT LINKED TO SMO (SMO)
565	Added procedure has been denied as a duplicate procedure because the maximum allowed daily occurrences of this procedure was exceeded due to current codes.
584	Current procedure is flagged because the indicated procedure is inappropriate for patient's sex.
595	Current multi-unit line contains units, which have been denied for more than one reason. (Split-Decision)
596	Code added due to SPL claim
622	OUTPATIENT AND INPATIENT HOSPITAL SERVICES ON SAME DAY
651	HOSPITAL CUTBACK APPLIED
701	CONSULT FOLLOW-UP VISITS NOT ALLOWED.
711	SAME SPECIALTY/SUBSPECIALTY PAID ON SAME DATE OF SERV
715	FOUND DUPLICATE VISIT SAME DAY
727	EXCEEDS DAILY SERVICE MAXIMUM
730	ONE INP HOSP INITIAL/SUBSEQ CARE VISIT ALLOWED PER DAY
790	3 HOSPITAL INPATIENT SERV PAID FOR SAME DATE OF SERVICE
792	Bypass ClaimCheck edits
795	Bypass PAM edits
851	SUSPCT DUPLICATE ERROR: IDENTICAL HOSPITAL CLAIMS
855	SUSPCT DUPLICATE ERROR: IDENTICAL OUTPATIENT CLAIMS
863	SUSPCT DUPLICATE ERROR:IDENTICAL PHYSICIAN CLAIMS
918	MEDICAID ALLOWABLE AMOUNT REDUCED BY OTHER INSURANCE
919	MEDICAID ALLOWABLE AMOUNT REDUCED BY RECIPIENT SPENDOWN
921	UNITS DON'T MATCH THE SITE SPECIFIC MODIFIERS
947	E305 – MAXIMUM EXCEEEDED FOR ADDED CLAIM LINES. PLEASE SPLIT CLAIM AND RESUBMIT.
961	INVALID PROCEDURE-MODIFIER COMBINATION/CLAIMCHECK
962	MAXIMUM SERVICES EXCEEDED SAME DAY/CLAIMCHECK
964	Integration Wizard Defined AUDIT-RESULT
967	Integration Wizard Defined AUDIT-RESULT

EDIT CODE	EDIT DISPOSITION – INFORMATION ONLY (E) EDIT DESCRIPTION
969	Integration Wizard Defined AUDIT-RESULT
977	Integration Wizard Defined AUDIT-RESULT
978	CALCULATED PRICING IS ZERO/CALL HELP DESK
981	Integration Wizard Defined AUDIT-RESULT
029	SERVICE MORE THAN 12 MONTHS OLD
030	SERVICE THRU DATE TOO OLD
084	TREATMENT PLACE INVALID
108	PROVIDER TYPE SERVICES NOT COVERED FOR RECIPIENT AGE
142	BILLING PROVIDER NPI MISSING/NOT ON FILE
143	SERVING PROVIDER NPI MISSING/NOT ON FILE
145	BILLING PROVIDER NPI MISMATCH
146	SERVICING PROVIDER NPI MISMATCH
201	PROVIDER NOT ELIGIBLE ON DATES OF SERVICE
207	BILLING PROVIDER INELIGIBLE ON DATE OF SERVICE
272	CLAIM EXCEEDS 1 YEAR FILING LIMIT
279	INVALID PLACE OF TREATMENT FOR PROF COMP
294	RECIPIENT NOT ON FILE RECYCLED 3 TIMES
295	RECIPIENT INELIGIBLE RECYCLED THREE TIMES
297	DECLARED BANKRUPTCY.FILE W/CARRIER FOR POSSIBLE PMTS.
330	QUALIFIED MEDICARE BENEFICIARY NOT MEDICAID ELIGIBLE
427	PSYCHIATRIC SERVICES NOT COVERED UNDER HOME HEALTH
546	Code added due to a REB of a current code only
550	MULTIPLE PROVIDERS WILL NOT BE PAID FOR THIS PROCEDURE
556	ATTENDING/SERVICING PROVIDER IS NOT LINKED TO SMO (SMO)
565	Added procedure has been denied as a duplicate procedure because the maximum allowed daily occurrences of this procedure was exceeded due to current codes.
584	Current procedure is flagged because the indicated procedure is inappropriate for patient's sex.
595	Current multi-unit line contains units, which have been denied for more than one reason. (Split-Decision)
596	Code added due to SPL claim
622	OUTPATIENT AND INPATIENT HOSPITAL SERVICES ON SAME DAY
651	HOSPITAL CUTBACK APPLIED
701	CONSULT FOLLOW-UP VISITS NOT ALLOWED.
711	SAME SPECIALTY/SUBSPECIALTY PAID ON SAME DATE OF SERV
715	FOUND DUPLICATE VISIT SAME DAY
727	EXCEEDS DAILY SERVICE MAXIMUM
730	ONE INP HOSP INITIAL/SUBSEQ CARE VISIT ALLOWED PER DAY
790	3 HOSPITAL INPATIENT SERV PAID FOR SAME DATE OF SERVICE
792	Bypass ClaimCheck edits
795	Bypass PAM edits

EDIT CODE	EDIT DISPOSITION – INFORMATION ONLY (E) EDIT DESCRIPTION
851	SUSPCT DUPLICATE ERROR: IDENTICAL HOSPITAL CLAIMS
855	SUSPCT DUPLICATE ERROR: IDENTICAL OUTPATIENT CLAIMS
863	SUSPCT DUPLICATE ERROR:IDENTICAL PHYSICIAN CLAIMS
918	MEDICAID ALLOWABLE AMOUNT REDUCED BY OTHER INSURANCE
919	MEDICAID ALLOWABLE AMOUNT REDUCED BY RECIPIENT SPENDOWN
921	UNITS DON'T MATCH THE SITE SPECIFIC MODIFIERS
947	E305 – MAXIMUM EXCEEEDED FOR ADDED CLAIM LINES. PLEASE SPLIT CLAIM AND RESUBMIT.
961	INVALID PROCEDURE-MODIFIER COMBINATION/CLAIMCHECK
962	MAXIMUM SERVICES EXCEEDED SAME DAY/CLAIMCHECK
964	Integration Wizard Defined AUDIT-RESULT
967	Integration Wizard Defined AUDIT-RESULT
969	Integration Wizard Defined AUDIT-RESULT
977	Integration Wizard Defined AUDIT-RESULT
978	CALCULATED PRICING IS ZERO/CALL HELP DESK
981	Integration Wizard Defined AUDIT-RESULT

EDIT CODE	EDIT DISPOSITION - NON REPAIRABLE DENIALS EDIT DESCRIPTION
117	MAXIMUM OF 2 DAYS ALLOWED TO TRANSFER MHISA PATIENTS
210	PROVIDER NOT CERTIFIED FOR THIS PROCEDURE
219	EPSDT REFERRAL FOR RECIPIENT OVER 21 years old
222	RECIPIENT INELIGIBLE ON ONE OR MORE SERVICE DATE(S)
231	NDC IS NOT ON THE PROCUDURE FORMULARY FILE
233	PROCEDURE/NDC NOT COVERED FOR SERVICE DATE GIVEN
234	PROCEDURE/NDC NOT COVERED FOR AGE GIVEN
237	PROCEDURE/NDC NOT COVERED FOR PROVIDER SPECIALTY GIVEN
293	RECYCLED RECIPIENT INELIGIBLE ON DOS
299	PROCEDURE/DRUG NOT COVERED BY MEDICAID
367	ADJUSTMENT DENIED/ORIG CLAIM PAID CORRECTLY
508	WAIVER SVC NOT PAYABLE WHILE IP
528	LACHIP AFFORDABLE PLAN - SUBMIT CLAIM TO LOUISIANA OFFICE OF GROUP BENEFITS
530	RECIPIENT WAS REIMBURSED FOR THIS SERVICE
631	EPSDT AGE OVER 21
642	ONLY 1 INITIAL CONSULT-SAME PHYS.PER HOSPITALIZATION
644	VISIT CODE ALREADY PAID FOR THIS DATE OF SERVICE
673	EVAL AND MGT CODE PAID FOR THIS DOS
689	MHR SERVICES ALREADY PAID FOR THIS DATE OF SERVICE

EDIT CODE	EDIT DISPOSITION - NON REPAIRABLE DENIALS EDIT DESCRIPTION
695	ONE HOSPITAL DISCHARGE SERVICE PAID PER ADMISSION
704	ER VISIT ON DATE OF INP HOS SERVICES
712	ONE INITIAL HOSPITAL INPATIENT SERVICE PAID PER ADMISS
716	PROCEDURE INCLUDED IN THE PHYSICIAN OFFICE VISIT
735	PREVIOUSLY PAID ANES.OR SUPERVISING ANES SAME RECI/DOS
746	SAME ATTENDING PROV PAID INPT CONSULTATION SAME STAY
758	FOUND DUPLICATE SERVICE SAME DAY
791	BILLED CODE CONFLICTS WITH CODE ALREADY PAID
794	INPT HOSP SERV PAID FOR SAME DOS TO SAME ATTENDING PROV
797	DUPLICATE ADJUSTMENT RECORDS ENTERED
798	HISTORY RECORD ALREADY ADJUSTED
800	DUPLICATE OF PREVIOUSLY PAID CLAIM
801	EXACT DUPLICATE ERROR: IDENTICAL HOSPITAL CLAIMS
802	EXACT DUPLICATE ERROR: HOSPITAL AND TITLE18-INSTITUTION
805	EXACT DUPLICATE ERROR: IDENTICAL OUTPATIENT CLAIMS
806	EXACT DUPLICATE ERROR: OUTPATIENT AND REHAB SERVICES
813	EXACT DUPLICATE ERROR: IDENTICAL PHYSICIAN CLAIMS
814	EXACT DUPLICATE ERROR: PHYSICIAN AND TITLE18
849	ALREADY PAID SAME ATTENDING DIFFERENT BILLING PROVIDER
898	EXACT DUPE SAME ICN - DROPPED
926	EXACT DUPLICATE OF ANOTHER ADJUSTMENT.
942	DENIED BY MEDICARE NOT COVERED BY MEDICAID
948	INCLUDED IN MAJOR SURGICAL PROCEDURE
951	DATE OF DISCHARGE NOT COVERED
952	INCLUDED IN OFFICE VISIT/RELATED PROCEDURE
954	INAPPROPRIATE PROCEDURE - SEE CPT FOR VALID CODE
972	ALLOWABLE AMOUNT PAID IN FULL BY MEDICARE
117	MAXIMUM OF 2 DAYS ALLOWED TO TRANSFER MHISA PATIENTS
210	PROVIDER NOT CERTIFIED FOR THIS PROCEDURE
219	EPSDT REFERRAL FOR RECIPIENT OVER 21 years old
222	RECIPIENT INELIGIBLE ON ONE OR MORE SERVICE DATE(S)
231	NDC IS NOT ON THE PROCUDURE FORMULARY FILE
233	PROCEDURE/NDC NOT COVERED FOR SERVICE DATE GIVEN
234	PROCEDURE/NDC NOT COVERED FOR AGE GIVEN
237	PROCEDURE/NDC NOT COVERED FOR PROVIDER SPECIALTY GIVEN
293	RECYCLED RECIPIENT INELIGIBLE ON DOS
299	PROCEDURE/DRUG NOT COVERED BY MEDICAID
367	ADJUSTMENT DENIED/ORIG CLAIM PAID CORRECTLY
508	WAIVER SVC NOT PAYABLE WHILE IP

EDIT CODE	EDIT DISPOSITION - NON REPAIRABLE DENIALS EDIT DESCRIPTION
528	LACHIP AFFORDABLE PLAN - SUBMIT CLAIM TO LOUISIANA OFFICE OF GROUP BENEFITS
530	RECIPIENT WAS REIMBURSED FOR THIS SERVICE
631	EPSDT AGE OVER 21
642	ONLY 1 INITIAL CONSULT-SAME PHYS.PER HOSPITALIZATION
644	VISIT CODE ALREADY PAID FOR THIS DATE OF SERVICE
673	EVAL AND MGT CODE PAID FOR THIS DOS
689	MHR SERVICES ALREADY PAID FOR THIS DATE OF SERVICE
695	ONE HOSPITAL DISCHARGE SERVICE PAID PER ADMISSION
704	ER VISIT ON DATE OF INP HOS SERVICES
712	ONE INITIAL HOSPITAL INPATIENT SERVICE PAID PER ADMISS
716	PROCEDURE INCLUDED IN THE PHYSICIAN OFFICE VISIT
735	PREVIOUSLY PAID ANES.OR SUPERVISING ANES SAME RECI/DOS
746	SAME ATTENDING PROV PAID INPT CONSULTATION SAME STAY
758	FOUND DUPLICATE SERVICE SAME DAY
791	BILLED CODE CONFLICTS WITH CODE ALREADY PAID
794	INPT HOSP SERV PAID FOR SAME DOS TO SAME ATTENDING PROV
797	DUPLICATE ADJUSTMENT RECORDS ENTERED
798	HISTORY RECORD ALREADY ADJUSTED
800	DUPLICATE OF PREVIOUSLY PAID CLAIM
801	EXACT DUPLICATE ERROR: IDENTICAL HOSPITAL CLAIMS
802	EXACT DUPLICATE ERROR: HOSPITAL AND TITLE18-INSTITUTION
805	EXACT DUPLICATE ERROR: IDENTICAL OUTPATIENT CLAIMS
806	EXACT DUPLICATE ERROR: OUTPATIENT AND REHAB SERVICES
813	EXACT DUPLICATE ERROR: IDENTICAL PHYSICIAN CLAIMS
814	EXACT DUPLICATE ERROR: PHYSICIAN AND TITLE18
849	ALREADY PAID SAME ATTENDING DIFFERENT BILLING PROVIDER
898	EXACT DUPE SAME ICN - DROPPED
926	EXACT DUPLICATE OF ANOTHER ADJUSTMENT.
942	DENIED BY MEDICARE NOT COVERED BY MEDICAID
948	INCLUDED IN MAJOR SURGICAL PROCEDURE
951	DATE OF DISCHARGE NOT COVERED
952	INCLUDED IN OFFICE VISIT/RELATED PROCEDURE
954	INAPPROPRIATE PROCEDURE - SEE CPT FOR VALID CODE
972	ALLOWABLE AMOUNT PAID IN FULL BY MEDICARE

Appendix G

Provider Directory/Network Provider and Subcontractor Registry

The SMO will be required to provide DHH-OBH with a list of contracted providers including various data elements that are publicly available from NPPES through the Freedom of Information Act (FOIA). DHH-OBH shall be provided advance copies of all updates not less than ten (10) working days in advance of distribution. Any providers no longer taking patients must be clearly identified. Under the FOIA, CMS allowed disclosure of NPPES health care provider data available beginning Tuesday, September 4, 2007. The NPI Registry became operational on September 4th and CMS posted the downloadable file on September 12th, 2007.

At the onset of the SMO Contract and periodically as changes are necessary, the SMO should submit to Molina a provider directory/registry.

The following file layout describes the data characteristics and structure of the Provider Registry File as it should be submitted by the SMO to Molina. This file layout is followed by the MMIS allowed Provider Types and Provider Specialties.

Provider Registry File Layout

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
NOTE: This record format describes a fixed-format layout. The record size is fixed at 750 bytes. If a field is listed as Optional (O), and the SMO elects not to populate the field, then it should be filled with blanks or zeros as appropriate to the Length and Format definition (character or numeric, respectively).					
1-20	NPI	National Provider ID number	20	First 10 characters should represent the	R

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
				NPI. Last 10 characters should be spaces. If the number has leading zeroes, be sure to include them.	
21	Delimiter		1	Character, use the ^ character value	
22	Entity Type code	1=Individual, 2=Organization	1		R
23	Delimiter		1	Character, use the ^ character value	
24-43	Replacement NPI	DO NOT USE AT THIS TIME. FOR FUTURE USE.	20	First 10 characters should represent the NPI. Last 10 characters should be spaces. If the number has leading zeroes, be sure to use them.	O
44	Delimiter		1	Character, use the ^ character value	
45-74	Provider Name OR the Legal Business Name for Organizations. If the entity type=1 (individual), please format the name in this manner: First 13 positions= provider first name, 14th position=middle initial (or space), 15-27th		30	Character	R

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
	characters=last name, 28-30th positions=suffix. If names do not fit in these positions, please truncate the end of the item so that it fits in the positions.				
75	Delimiter		1	Character, use the ^ character value	
76-105	Provider Business Mailing Address (First line address)		30	Character	R
106	Delimiter		1	Character, use the ^ character value	
107-136	Provider Business Mailing Address (Second line address)		30	Character	O
137	Delimiter		1	Character, use the ^ character value	
138-167	Provider Business Mailing Address (City,)		30	Character	R
168	Delimiter		1	Character, use the ^ character value	
169-170	Provider Business Mailing Address (State)	USPS state code abbreviation	2	Character	R
171	Delimiter		1	Character, use the ^ character value	
172-181	Provider Business Mailing Address (9-Digit Postal Code)		10	Character, left-justify, right-fill with spaces if necessary	R
182	Delimiter		1	Character, use the ^	

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
				character value	
183-192	Provider Business Mailing Address (Country Code if outside U.S.)	Leave blank if business mailing address is not outside the U.S.	10	Character, left-justify, right-fill with spaces if necessary	O
193	Delimiter		1	Character, use the ^ character value	
194-203	Provider Business Mailing Address (Telephone Number)	Do not enter dashes or parentheses.	10	Numeric	R
204	Delimiter		1	Character, use the ^ character value	
205-214	Provider Business Mailing Address (Fax Number)	Do not enter dashes or parentheses.	10	Numeric	O
215	Delimiter		1	Character, use the ^ character value	
216-245	Provider Business Location Address (First line address)	No P.O. Box here, please use a physical address.	30	Character	R
246	Delimiter		1	Character, use the ^ character value	
247-276	Provider Business Location Address (Second line address)		30	Character	O
277	Delimiter		1	Character, use the ^ character value	
278-307	Provider Business Location Address (City,)		30	Character	R
308	Delimiter		1	Character, use the ^	

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
				character value	
309-310	Provider Business Location Address (State)		2	USPS state code abbreviation	R
311	Delimiter		1	Character, use the ^ character value	
312-321	Provider Business Location Address (Postal Code)		10	Character, left-justify, right-fill with spaces if necessary	R
322	Delimiter		1	Character, use the ^ character value	
323-332	Provider Business Location Address (Country Code if outside U.S)	Leave blank if business mailing address is not outside the U.S.	10	Character, left-justify, right-fill with spaces if necessary	O
333	Delimiter		1	Character, use the ^ character value	
334-343	Provider Business Location Address (Telephone Number)	Do not enter dashes or parentheses.	10	Numeric	R
344	Delimiter		1	Character, use the ^ character value	
345-354	Provider Business Location Address (Fax Number)	Do not enter dashes or parentheses.	10	Numeric	O
355	Delimiter		1	Character, use the ^ character value	
356-365	Healthcare Provider Taxonomy Code 1		10	Character	R Note: if a single NPI is used for multiple entities then we require at

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
					least 1 taxonomy per NPI. For example, if a single NPI is used for an acute care hospital as well as a DPPU in the hospital, then we need taxonomy for both units… each sent in a separate record.
366	Delimiter		1	Character, use the ^ character value	
367-376	Healthcare Provider Taxonomy Code 2	Use if necessary; otherwise leave blank.	10	Character	O
377	Delimiter		1	Character, use the ^ character value	
378-387	Healthcare Provider Taxonomy Code 3	Use if necessary; otherwise leave blank.	10	Character	O
388	Delimiter		1	Character, use the ^ character value	
389-395	Other Provider Identifier	If available, enter the provider's Louisiana Medicaid Provider ID	7	Numeric, left-fill with zeroes.	R, if provider is already enrolled with Medicaid; otherwise, optional.
396	Delimiter		1	Character, use the ^ character value	
397-400	Other Provider Identifier Type	Provider Type and Provider	4	1st 2 characters are provider type; last 2	R

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
	Code	Specialty		characters (3-4) are provider specialty. See SMO Companion Guide for list of applicable provider types and specialties.	
401	Delimiter		1	Character, use the ^ character value	
402-409	Provider Enumeration Date	NPPES enumeration date.	8	Numeric, format YYYYMMDD	R
410	Delimiter		1	Character, use the ^ character value	
411-418	Last Update Date	NPPES last update date; leave all zeros if not available.	8	Numeric, format YYYYMMDD	O
419	Delimiter		1	Character, use the ^ character value	
420-439	NPI Deactivation Reason Code	NPPES deactivation reason; leave blank if appropriate.	20	Left justify, right-fill with spaces.	O
440	Delimiter		1	Character, use the ^ character value	
441-448	NPI Deactivation Date	NPPES deactivation date; leave all zeros if not appropriate.	8	Numeric, format YYYYMMDD	O
449	Delimiter		1	Character, use the ^ character value	
450-457	NPI Reactivation Date	NPPES reactivation date; leave all zeros if not appropriate.	8	Numeric, format YYYYMMDD	O
458	Delimiter		1	Character, use the ^ character value	

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
459	Provider Gender Code	M=Male, F=Female, N=Not applicable	1	Character .	R
460	Delimiter		1	Character, use the ^ character value	
461-480	Provider License Number		20	Character, left-justified, right-fill with spaces.	R
481	Delimiter		1	Character, use the ^ character value	
482-483	Provider License Number State Code	2-character USPS state code value	2	Character	R
484	Delimiter		1	Character, use the ^ character value	
485-534	Authorized Official Contact Information (First Name, Middle Name, Last Name)		50	Character, left-justified, right-fill with spaces.	R
535	Delimiter		1	Character, use the ^ character value	
536-565	Authorized Official Contact Information (Title or Position)		30	Character, left-justified, right-fill with spaces.	O
566	Delimiter		1	Character, use the ^ character value	
567-576	Authorized Official Contact Information (Telephone Number)	Do not enter dashes or parentheses.	10	Numeric	R
577	Delimiter		1	Character, use the ^ character value	
578	Panel Open Indicator	Y=Yes, panel is open.	1	Character	R for PCPs; otherwise

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
		N=No, panel is not open.			optional.
579	Delimiter		1	Character, use the ^ character value	
580	Language Indicator 1 (this is the primary language indicator)	1=English-speaking patients only 2=Accepts Spanish-speaking patients 3=Accepts Vietnamese-speaking patients 4=Accepts French-speaking patients 5=Accepts Cambodian-speaking patients	1	Character	R for PCPs, specialists and other professionals; otherwise optional.
581	Delimiter		1	Character, use the ^ character value	
582	Language Indicator 2 (this is a secondary language indicator)	0=no other language supported 1= Accepts English-speaking patients 2=Accepts Spanish-speaking patients 3=Accepts Vietnamese-speaking patients 4=Accepts French-speaking patients 5=Accepts Cambodian-speaking patients	1	Character	O
583	Delimiter		1	Character, use the ^ character value	

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
584	Language Indicator 3 (this is a secondary language indicator)	0=no other language supported 1=English-speaking patients only 2=Accepts Spanish-speaking patients 3=Accepts Vietnamese-speaking patients 4=Accepts French-speaking patients 5=Accepts Cambodian-speaking patients	1	Character	O
585	Delimiter		1	Character, use the ^ character value	
586	Language Indicator 4 (this is a secondary language indicator)	0=no other language supported 1=English-speaking patients only 2=Accepts Spanish-speaking patients 3=Accepts Vietnamese-speaking patients 4=Accepts French-speaking patients 5=Accepts Cambodian-speaking patients	1	Character	O
587	Delimiter		1	Character, use the ^ character value	
588	Language	0=no other	1	Character	O

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
	Indicator 5 (this is a secondary language indicator)	language supported 1=English-speaking patients only 2=Accepts Spanish-speaking patients 3=Accepts Vietnamese-speaking patients 4=Accepts French-speaking patients 5=Accepts Cambodian-speaking patients			
589	Delimiter		1	Character, use the ^ character value	
590	Age Restriction Indicator	0=no age restrictions 1=adult only 2=pediatric only	1	Character	R for PCPs, specialists and other professionals; otherwise optional.
591	Delimiter		1	Character, use the ^ character value	
592-596	PCP Linkage Maximum	Numeric	5	Numeric, left fill with zeroes. This number represents the maximum number of patients that can be linked to the PCP. It should be left all zeroes if the provider is not a PCP/specialist.	R for PCPs; otherwise optional.
597	Delimiter		1	Character, use the ^ character value	
598-602	PCP Linkages with SMO	Numeric	5	Numeric, left fill with zeroes. This	R for PCPs; otherwise

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
				number represents the maximum number of SMO enrollees that can be linked to the PCP. It should be left all zeroes if the provider is not a PCP/specialist.	optional.
603	Delimiter		1	Character, use the ^ character value	
604-608	PCP Linkages with Others	Numeric	5	Numeric, left fill with zeroes. This number represents the maximum number of enrollees in other plans (not SMO) that can be linked to the PCP. It should be left all zeroes if the provider is not a PCP/specialist.	R for PCPs; otherwise optional.
609	Delimiter		1	Character, use the ^ character value	
610	SMO Enrollment Indicator	N=New enrollment C=Change to existing enrollment D=Disenrollment	1	Use this field to identify new providers, changes to existing providers, and disenrolled providers	R
611	Delimiter		1	Character, use the ^ character value	
612-619	SMO Enrollment Indicator Effective Date	Effective date of Enrollment Indicator above.	8	Numeric, format YYYYMMDD	R
620	Delimiter		1	Character, use the ^ character value	
621	Family Only Indicator	0=no restrictions 1=family members only	1		R for PCPs; otherwise optional.

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
622	Delimiter		1	Character, use the ^ character value	
623-624	Provider Sub-Specialty 1	Value set is determined by DHH and is available in SMO Companion Guide	2		R for PCPs; otherwise optional
625	Delimiter		1	Character, use the ^ character value	
626-627	Provider Sub-Specialty 2	If necessary, Value set is determined by DHH and is available in SMO Companion Guide	2		O
628	Delimiter		1	Character, use the ^ character value	
629-630	Provider Sub-Specialty 3	If necessary, Value set is determined by DHH and is available in SMO Companion Guide	2		O
631	Delimiter		1	Character, use the ^ character value	
632-661	SMO Contract Name or Number	This should represent the contract name/number that is established between the SMO and the Provider	30	Character	R
662	Delimiter		1	Character, use the ^ character value	
663-670	SMO Contract Begin Date	Date that the contract between	8	Numeric date value in the form	R

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
		the SMO and the provider started		YYYYMMDD	
671	Delimiter		1	Character, use the ^ character value	
672-679	SMO Contract Term Date	Date that the contract between the SMO and the provider was terminated.	8	Numeric date value in the form YYYYMMDD	O
680	Delimiter		1	Character, use the ^ character value	
681-682	Provider Parish served – 1st or primary	Parish code value that represents the primary parish that the provider serves	2	2-digit parish code value. See the SMO Companion Guide.	R
683	Delimiter		1	Character, use the ^ character value	
684-685	Provider Parish served – 2nd	Parish code value that represents a secondary or other parish that the provider serves. Use only if necessary; otherwise enter 00.	2	2-digit parish code value. See the SMO Companion Guide.	O
686	Delimiter		1	Character, use the ^ character value	
687-688	Provider Parish served – 3rd	Parish code value that represents a secondary or other parish that the provider serves. Use only if necessary;	2	2-digit parish code value. See the SMO Companion Guide.	O

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
		otherwise enter 00.			
689	Delimiter		1	Character, use the ^ character value	
690-691	Provider Parish served – 4th	Parish code value that represents a secondary or other parish that the provider serves. Use only if necessary; otherwise enter 00.	2	2-digit parish code value. See the SMO Companion Guide.	O
692	Delimiter		1	Character, use the ^ character value	
693-694	Provider Parish served – 5th	Parish code value that represents a secondary or other parish that the provider serves. Use only if necessary; otherwise enter 00.	2	2-digit parish code value. See the SMO Companion Guide.	O
695	Delimiter		1	Character, use the ^ character value	
696-697	Provider Parish served – 6th	Parish code value that represents a secondary or other parish that the provider serves. Use only if necessary; otherwise enter 00.	2	2-digit parish code value. See the SMO Companion Guide.	O

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
698	Delimiter		1	Character, use the ^ character value	
699-700	Provider Parish served – 7th	Parish code value that represents a secondary or other parish that the provider serves. Use only if necessary; otherwise enter 00.	2	2-digit parish code value. See the SMO Companion Guide.	O
701	Delimiter		1	Character, use the ^ character value	
702-703	Provider Parish served – 8th	Parish code value that represents a secondary or other parish that the provider serves. Use only if necessary; otherwise enter 00.	2	2-digit parish code value. See the SMO Companion Guide.	O
704	Delimiter		1	Character, use the ^ character value	
705-706	Provider Parish served – 9th	Parish code value that represents a secondary or other parish that the provider serves. Use only if necessary; otherwise enter 00.	2	2-digit parish code value. See the SMO Companion Guide.	O
707	Delimiter		1	Character, use the ^ character value	

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
708-709	Provider Parish served – 10th	Parish code value that represents a secondary or other parish that the provider serves. Use only if necessary; otherwise enter 00.	2	2-digit parish code value. See the SMO Companion Guide.	O
710	Delimiter		1	Character, use the ^ character value	
711-712	Provider Parish served – 11th	Parish code value that represents a secondary or other parish that the provider serves. Use only if necessary; otherwise enter 00.	2	2-digit parish code value. See the SMO Companion Guide.	O
713	Delimiter		1	Character, use the ^ character value	
714-715	Provider Parish served – 12th	Parish code value that represents a secondary or other parish that the provider serves. Use only if necessary; otherwise enter 00.	2	2-digit parish code value. See the SMO Companion Guide.	O
716	Delimiter		1	Character, use the ^ character value	
717-718	Provider Parish served – 13th	Parish code value that represents a	2	2-digit parish code value. See the SMO	O

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
		secondary or other parish that the provider serves. Use only if necessary; otherwise enter 00.		Companion Guide.	
719	Delimiter		1	Character, use the ^ character value	
720-721	Provider Parish served – 14th	Parish code value that represents a secondary or other parish that the provider serves. Use only if necessary; otherwise enter 00.	2	2-digit parish code value. See the SMO Companion Guide.	O
722	Delimiter		1	Character, use the ^ character value	
723-724	Provider Parish served – 15th	Parish code value that represents a secondary or other parish that the provider serves. Use only if necessary; otherwise enter 00.	2	2-digit parish code value. See the SMO Companion Guide.	O
725	Delimiter		1	Character, use the ^ character value	
726-749	Spaces	End of record filler	24	Enter all spaces	
750	End of record delimiter		1	Character, use the ^ character value	

The SMO is required to populate the provider type codes to a DHH valid provider type code as shown in the list below:

Provider Type and Description

Please note: Rows shaded in green are specific to SMO provider registry.

Provider Type	Description
01	Fiscal Agent - Waiver
02	Transitional Support - Waiver
03	Children's Choice - Waiver (in-state only)
04	Pediatric Day Health Care (PDHC) facility
06	NOW Professional (Registered Dietician, Psychologist, Social Worker)
07	Case Mgmt - Infants & Toddlers (in-state only)
08	Case Mgmt - Elderly (in-state only)
09	Hospice Services (in-state only)
10	Comprehensive Community Support Services
11	Shared Living - Waiver (in-state only)
12	Multi-Systemic Therapy (in-state only)
13	Pre-Vocational Habilitation (in-state only)
14	Adult Day Habilitation - Waiver (in-state only)
15	Environmental Accessibility Adaptation - Waiver (in-state only)
16	Personal Emergency Response Systems - Waiver
17	Assistive Devices - Waiver
18	Community Mental Health Center (in-state only)
19	Doctor of Osteopathy (DO) and Doctors of Osteopathy(DO) Group
20	Physician (MD) and Physician (MD) Group
21	EDI Billing Agent
22	Waiver Personal Care Attendant
23	Independent Lab
24	Personal Care Services (LTC/PCS/PAS) (in-state only)
25	Mobile X-Ray/Radiation Therapy Center
26	Pharmacy (out-of-state for crossovers only)

Provider Type	Description
27	Dentist and Dental Group
28	Optometrist and Optometrist Group
29	EarlySteps and EarlySteps Group (in-state only)
30	Chiropractor and Chiropractor Group
31	Medical or Licensed Psychologist
32	Podiatrist and Podiatrist Group
33	Prescribing Only Provider
34	Audiologist
35	Physical Therapist
36	Not assigned
37	Occupational Therapist
38	School-Based Health Center (in-state only)
39	Speech/Language Therapist
40	DME Provider (out-of-state for crossovers only)
41	Registered Dietician
42	Non-Emergency Medical Transportation (in-state only)
43	Case Mgmt - Nurse Home Visit - 1st Time Mother (in-state only)
44	Home Health Agency (in-state only)
45	Case Mgmt - Contractor (in-state only)
46	Case Mgmt - HIV (in-state only)
47	Case Mgmt - CMI
48	Case Mgmt - Pregnant Woman
49	Case Mgmt - DD
50	PACE Provider
51	Ambulance Transportation
53	Direct Care Worker
54	Ambulatory Surgical Center (in-state only)
55	Emergency Access Hospital
57	Not in Use: to-be used for RN
58	Not in Use: to-be used for LPN
59	Neurological Rehabilitation Unit (Hosp)
60	Hospital

Provider Type	Description
61	Venereal Disease Clinic
62	Tuberculosis Clinic
63	Tuberculosis Inpatient Hospital
64	Mental Health Hospital (Free-Standing)
65	Rehabilitation Center (in-state only)
66	KIDMED Screening Clinic (in-state only)
67	Prenatal Health Care Clinic
68	Substance Abuse and Alcohol Abuse Center
69	Hospital - Distinct Part Psychiatric Unit (in-state only)
70	LEA and School Board (EPSDT Health Services) (in-state only)
71	Family Planning Clinic
72	Federally Qualified Health Center (in-state only)
73	Licensed Clinical Social Worker (LCSW)
74	Mental Health Clinic
75	Optical Supplier (in-state only)
76	Hemodialysis Center (in-state only)
77	Mental Health Rehabilitation (in-state only)
78	Nurse Practitioner and Nurse Practitioner Group
79	Rural Health Clinic (Provider Based) (in-state only)
80	Nursing Facility (in-state only)
81	Case Mgmt - Ventilator Assisted Care Program
82	Personal Care Attendant - Waiver (in-state only)
83	Respite Care (Center Based)- Waiver (in-state only)
84	Substitute Family Care - Waiver (in-state only)
85	ADHC Home and Community Based Services - Waiver (in-state only)
86	ICF/DD Rehabilitation
87	Rural Health Clinic (Independent) (in-state only)
88	ICF/DD - Group Home (in-state only)
89	Supervised Independent Living - Waiver (in-state only)
90	Nurse-Midwife
91	CRNA or CRNA Group
92	Private Duty Nurse

Provider Type	Description
93	Clinical Nurse Specialist
94	Physician Assistant
95	American Indian / Native Alaskan "638" Facilities
96	Psychiatric Residential Treatment Facility
97	Adult Residential Care
98	Supported Employment - Waiver (in-state only)
99	Greater New Orleans Community Health Connection (in-state only)
AA	Assertive Community Treatment Team (ACT)
AB	Prepaid Inpatient Health Plan (PIHP)
AC	Family Support Organization
AD	Transition Coordination (Skills Building)
AE	Respite Care Service Agency
AF	Crisis Receiving Center
AG	Behavioral Health Rehabilitation Provider Agency
AH	Licensed Marriage & Family Therapist (LMFT)
AJ	Licensed Addiction Counselors (LAC)
AK	Licensed Professional Counselors (LPC).
AL	Community Choices Waiver Nursing
AM	Home Delivered Meals
AN	Caregiver Temporary Support

Below are the DHH provider specialty, subspecialties and types.

Provider Specialty, Subspecialty and Type

Specialty Code	Description	Type: 1=Specialty, 2=Subspecialty	Related Specialty (if Subspecialty)	Related Provider Types
00	All Specialties	1		n/a
01	General Practice	1		19,20
02	General Surgery	1		19, 20, 93
03	Allergy	1		19,20
04	Otology, Laryngology, Rhinology	1		19,20

Specialty Code	Description	Type: 1=Specialty, 2=Subspecialty	Related Specialty (if Subspecialty)	Related Provider Types
05	Anesthesiology	1		19, 20, 91
06	Cardiovascular Disease	1		19,20
07	Dermatology	1		19,20
08	Family Practice	1		19, 20, 78
09	Gynecology (DO only)	1		19
10	Gastroenterology	1		19,20
11	Not in Use	n/a		n/a
12	Manipulative Therapy (DO only)	1		19
13	Neurology	1		19,20
14	Neurological Surgery	1		19,20
15	Obstetrics (DO only)	1		19
16	OB/GYN	1		19, 20, 78, 90
17	Ophthalmology, Otology, Laryngology, Rhinology (DO only)	1		19
18	Ophthalmology	1		20
19	Orthodontist	1		19,20
20	Orthopedic Surgery	1		19,20
21	Pathologic Anatomy; Clinical Pathology (DO only)	1		19
22	Pathology	1		20
23	Peripheral Vascular Disease or Surgery (DO only)	1		19
24	Plastic Surgery	1		19,20
25	Physical Medicine Rehabilitation	1		19,20
26	Psychiatry	1		19, 20, 93
27	Psychiatry; Neurology (DO only)	1		19
28	Proctology	1		19,20
29	Pulmonary Diseases	1		19,20
30	Radiology	1		19,20
31	Roentgenology, Radiology (DO only)	1		19
32	Radiation Therapy (DO only)	1		19
33	Thoracic Surgery	1		19,20

Specialty Code	Description	Type: 1=Specialty, 2=Subspecialty	Related Specialty (if Subspecialty)	Related Provider Types
34	Urology	1		19,20
35	Chiropractor	1		30,35
36	Pre-Vocational Habilitation	1		13
37	Pediatrics	1		19, 20, 78
38	Geriatrics	1		19,20
39	Nephrology	1		19,20
40	Hand Surgery	1		19,20
41	Internal Medicine	1		19,20
42	Federally Qualified Health Centers	1		72
43	Not in Use	n/a		n/a
44	Public Health/EPSDT	1		66,70
45	NEMT - Non-profit	1		42
46	NEMT - Profit	1		42
47	NEMT - F+F	1		42
48	Podiatry - Surgical Chiropody	1		20, 32
49	Miscellaneous (Admin. Medicine)	1		20
50	Day Habilitation	1		14
51	Med Supply / Certified Orthotist	1		40
52	Med Supply / Certified Prosthetist	1		40
53	Med Supply / Certified Prosthetist Orthotist	1		40
54	Med Supply / Not Included in 51, 52, 53	1		40
55	Indiv Certified Orthotist	1		40
56	Indiv Certified Protherist	1		40
57	Indiv Certified Protherist - Orthotist	1		40
58	Indiv Not Included in 55, 56, 57	1		40
59	Ambulance Service Supplier, Private	1		51
60	Public Health or Welfare Agencies & Clinics	1		61, 62, 66, 67
61	Voluntary Health or Charitable Agencies	1		unknown
62	Psychologist Crossovers only	1		29, 31

Specialty Code	Description	Type: 1=Specialty, 2=Subspecialty	Related Specialty (if Subspecialty)	Related Provider Types
63	Portable X-Ray Supplier (Billing Independently)	1		25
64	Audiologist (Billing Independently)	1		29,34
65	Indiv Physical Therapist	1		29,35
66	Dentist, DDS, DMS	1		27
67	Oral Surgeon - Dental	1		27
68	Pedodontist	1		27
69	Independent Laboratory (Billing Independently)	1		23
70	Clinic or Other Group Practice	1		19, 20, 68, 74, 76, 91, 38
71	Speech Therapy	1		29
72	Diagnostic Laboratory	1		23
73	Social Worker Enrollment	1		73
74	Occupational Therapy	1		29,37
75	Other Medical Care	1		65
76	Adult Day Care	1		85
77	Habilitation	1		85
78	Mental Health Rehab	1		77
79	Nurse Practitioner	1		78
80	Environmental Modifications	1		15
81	Case Management	1		07, 08, 43, 46, 81
82	Personal Care Attendant	1		82
83	Respite Care	1		83
84	Substitute Family Care	1		84
85	Extended Care Hospital	1		60
86	Hospitals and Nursing Homes	1		55, 59, 60, 64, 69, 80, 88
87	All Other	1		26,40,44, 60
88	Optician / Optometrist	1		28,75
89	Supervised Independent Living	1		89
90	Personal Emergency Response Sys	1		16

Specialty Code	Description	Type: 1=Specialty, 2=Subspecialty	Related Specialty (if Subspecialty)	Related Provider Types
	(Waiver)			
91	Assistive Devices	1		17
92	Prescribing Only Providers	1		33
93	Hospice Service for Dual Elig.	1		09
94	Rural Health Clinic	1		79,87
95	Psychologist (PBS Program Only)	1		31
96	Psychologist (PBS Program and X-Overs)	1		31
97	Family Planning Clinic	1		71
98	Supported Employment	1		98
99	Provider Pending Enrollment	1		n/a
1A	Adolescent Medicine	2	37	19,20
1B	Diagnostic Lab Immunology	2	37	19,20
1C	Neonatal Perinatal Medicine	2	37	19,20
1D	Pediatric Cardiology	2	37	19,20
1E	Pediatric Critical Care Medicine	2	37	19,20
1F	Pediatric Emergency Medicine	2	37	19,20
1G	Pediatric Endocrinology	2	37	19,20
1H	Pediatric Gastroenterology	2	37	19,20
1I	Pediatric Hematology - Oncology	2	37	19,20
1J	Pediatric Infectious Disease	2	37	19,20
1K	Pediatric Nephrology	2	37	19,20
1L	Pediatric Pulmonology	2	37	19,20
1M	Pediatric Rheumatology	2	37	19,20
1N	Pediatric Sports Medicine	2	37	19,20
1P	Pediatric Surgery	2	37	19,20
1S	BRG - Med School	2		19,20
1T	Emergency Medicine	1		19,20
1Z	Pediatric Day Health Care	1		04
2A	Cardiac Electrophysiology	2	41	19,20
2B	Cardiovascular Disease	2	41	19,20
2C	Critical Care Medicine	2	41	19,20

Specialty Code	Description	Type: 1=Specialty, 2=Subspecialty	Related Specialty (if Subspecialty)	Related Provider Types
2D	Diagnostic Laboratory Immunology	2	41	19,20
2E	Endocrinology & Metabolism	2	41	19,20
2F	Gastroenterology	2	41	19,20
2G	Geriatric Medicine	2	41	19,20
2H	Hematology	2	41	19,20
2I	Infectious Disease	2	41	19,20
2J	Medical Oncology	2	41	19,20
2K	Nephrology	2	41	19,20
2L	Pulmonary Disease	2	41	19,20
2M	Rheumatology	2	41	19,20
2N	Surgery - Critical Care	2	41	19,20
2P	Surgery - General Vascular	2	41	19,20
2Q	Nuclear Medicine	1		19,20
2R	Physician Assistant	1		94
2S	LSU Medical Center New Orleans	2		19,20
2T	American Indian / Native Alaskan	2		95
2Y	OPH Genetic Disease Program	1		40
3A	Critical Care Medicine	2	16	19,20
3B	Gynecologic oncology	2	16	19,20
3C	Maternal & Fetal Medicine	2	16	19,20
3D	Community Choices Waiver - Respiratory Therapy	2	87, 75	44, 65
3E	Community Choices Waiver - PT and OT	2	87, 75	44, 66
3F	Community Choices Waiver - PT and S/L T	2	87, 75	44, 67
3G	Community Choices Waiver - PT and RT	2	87, 75	44, 68
3H	Community Choices Waiver - OT and S/L T	2	87, 75	44, 69
3J	Community Choices Waiver - OT and RT	2	87, 75	44, 70
3K	Community Choices Waiver - S/L T and RT	2	87, 75	44, 71
3L	Community Choices Waiver - PT, OT &	2	87, 75	44, 72

Specialty Code	Description	Type: 1=Specialty, 2=Subspecialty	Related Specialty (if Subspecialty)	Related Provider Types
	S/L T			
3M	Community Choices Waiver - PT, OT & RT	2	87, 75	44, 73
3N	Community Choices Waiver - PT, S/L T & RT	2	87, 75	44, 74
3Q	Community Choices Waiver - OT, S/L T & RT	2	87, 75	44, 75
3R	Community Choices Waiver - All Skilled Maintenance Therapies (PT, OT, S/L T, RT)	2	87, 75	44, 76
3S	LSU Medical Center Shreveport	2		19,20
3U	Community Choices Waiver – Assistive Devices – Home Health	2		
4A	Home and Community-Based Services	1		01,02
4B	NOW RN	1		06
4C	NOW LPN	1		06
4D	NOW Psychologist	1		06
4E	NOW Social Worker	1		06
4R	Registered Dietician	1		41
4S	Ochsner Med School	2		19,20
4W	Waiver Services	1		42
4X	Waiver-Only Transportation	1		42
5A	PCS-LTC	1		24
5B	PCS-EPSDT	1		24
5C	PAS	1		24
5D	PCS-LTC, PCS-EPSDT	1		24
5E	PCS-LTC, PAS	1		24
5F	PCS-EPSDT, PAS	1		24

Specialty Code	Description	Type: 1=Specialty, 2=Subspecialty	Related Specialty (if Subspecialty)	Related Provider Types
5G	OCS-LTC, PCS-EPSDT, PAS	1		24
5H	Community Mental Health Center			18
5I	Statewide Management Organization (SMO)	1		AB
5J	Youth Support	1		AC
5K	Family Support	1		AC
5L	Both Youth and Family Support	1		AC
5M	Multi-Systemic Therapy			12
5N	Substance Abuse and Alcohol Abuse Center	1		68
5P	PACE	1		50
5S	Tulane Med School	2		19,20
5U	Individual	1		AD
5V	Agency/Business	1		AD
5W	Community Choices Waiver - Personal Assistance Service	2	87	44
5X	Therapeutic Group Homes	1		96
5Y	PRCS Addiction Disorder	1		
5Z	Therapeutic Group Home Disorder	1		96
6A	Psychologist -Clinical	1		31
6B	Psychologist-Counseling	1		31
6C	Psychologist - School	1		31
6D	Psychologist - Developmental	1		31
6E	Psychologist - Non-Declared	1		31
6F	Psychologist - All Other	1		31
6H	LaPOP	1		01
6N	Endodontist	1		27
6P	Periodontist	1		27
6S	E Jefferson Fam Practice Ctr - Residency Program	2		19,20
6T	Community Choices Waiver - Physical	2	65, 87, 75	35, 44, 65

Specialty Code	Description	Type: 1=Specialty, 2=Subspecialty	Related Specialty (if Subspecialty)	Related Provider Types
	Therapy			
7A	SBHC - NP - Part Time - less than 20 hrs week	1		38
7B	SBHC - NP - Full Time - 20 or more hrs week	1		38
7C	SBHC - MD - Part Time - less than 20 hrs week	1		38
7D	SBHC - MD - Full Time - 20 or more hrs week	1		38
7E	SBHC - NP + MD - Part Time - combined less than 20 hrs week	1		38
7F	SBHC - NP + MD - Full Time - combined less than 20 hrs week	1		38
7G	Community Choices Waiver - Speech/Language Therapy	2	71, 87, 75	39, 44, 65
7H	Community Choices Waiver - Occupational Therapy	2	74, 87, 75	37, 44, 65
7M	Retail Convenience Clinics	2	70	19,20,78
7N	Urgent Care Clinics	2	70	19,20,79
7S	Leonard J Chabert Medical Center - Houma	2		19,20
8A	EDA & DD services	2	82	82, AH
8B	EDA services	2	82	82
8C	DD services	2	82	82
8D	Community Choices Waiver - Caregiver Temporary Support	1	82, 83	82, 83
8E	CSoC/Behavioral Health	1, 2		AB, AC, AD, AE, AF, AG, AH, AJ, AK, 82, 31, 68, 70, 73, 83, 53
8F	Community Choices Waiver - Caregiver Temporary Support - Home Health	2	8D	AN
8G	Community Choices Waiver - Caregiver Temporary Support - Assisted Living	2	8D	AN
8H	Community Choices Waiver - Caregiver Temporary Support - ADHC	2	8D	AN

Specialty Code	Description	Type: 1=Specialty, 2=Subspecialty	Related Specialty (if Subspecialty)	Related Provider Types
8J	Community Choices Waiver - Caregiver Temporary Support - Nursing Facility	2	8D	AN
8K	ADHC HCBS	1		AL
8L	Hospital-based PRTF	1		96
8M	Community Choices Waiver - Home-Delivered Meals	1		AM
8N	Community Choices Waiver - Nursing	2		44, 78
8P	Other specialization (other than Addiction Disorder)	1		96
8Q	Community Choices Waiver - EAA Assessor, Inspector, Approver	2		15
9B	Psychiatric Residential Treatment Facility	1		96
9D	Residential Care	1		97
9E	Children's Choice Waiver	1		03
9L	RHC/FQHC OPH Certified SBHC	1		72
9P	GNOCHC - Greater New Orleans Community Health Connection	1		99
9Q	PT 21 - EDI Independent Billing Company	2		21
9U	Medicare Advantage Plans	1		21
9V	OCDD - Point of Entry	1		21
9W	OAAS - Point of Entry	1		21
9X	OAD	1		21
9Y	Juvenile Court/Drug Treatment Center	1		21
9Z	Other Contract with a State Agency	1		21

Appendix H

Test Plan

This appendix provides a step-by-step account of the FI's plan for testing the ASC X12N 837 COB and 835 electronic transaction sets for use in submitting encounter data for storage in the MMIS claims history file. The plan consists of three (3) tiers of testing, which are outlined in detail below.

Testing Tier I

The first step in submitter testing is enrollment performed via Molina Electronic Data Interchange (EDI) Services, Inc. Each SMO must enroll with EDI to receive a Trading Partner ID in order to submit electronic encounter data. The SMO will already have an ID, but are only permitted to receive electronic transactions; e.g. 834, 820, not to submit them. In this step, permission is granted for the SMO to be able to both transmit and receive.

The second step performed concurrently with the enrollment, is EDIFECS testing. A partnership exists between EDIFECS and Molina Electronic Data Interchange (EDI) Services, Inc. to assist in compliance testing and tracking submitter test files prior to submission through the Molina Electronic Data Interchange (EDI). There are certain errors that will occur while testing with EDIFECS that shall not be considered when determining whether a SMO has passed or failed the EDIFECS portion of testing.

EDI must certify each SMO prior to the MMIS receipt of encounters via EDI. The objective is to ensure that the submitter can generate a valid X12 transaction, submit the transaction to the Molina Electronic Data Interchange (EDI), and that the transaction can be processed successfully with the resultant IRL, 997 Acceptance, or return transaction. X12 837 transactions (837I and 837P) must be in the 4010A (Addenda) format, not in the 4010 format. This phase of testing was designed to do the following:

- test connectivity with the Clearinghouse;
- validate Trading Partner IDs;
- validate the ability of the submitter to create and transmit X12 transactions with all required loops, segments, and data elements;
- validate the test submission with 997 Acceptance transactions; and
- generate IRL or paired transaction.

Once EDIFECS testing is complete, the SMO is certified that the X12 transaction is properly formatted to submit to the MMIS. The encounter claims data from the SMO is identified by the value 'RP' being present in X12 field TX-TYPE-CODE field. The SMO must ensure that their Medicaid IDs are in loop 2330B segment NM1 in 'Other Payer Primary Identification Number'. If line item SMO paid amount is submitted, they also need to populate the 'Other Payer Primary Identifier' in loop 2430 segment SVD with their Medicaid provider number. These fields are used in the MMIS pre-processors to indicate that the amount in the accompanying prior paid field is the SMO's paid amount and not TPL or any other COB amount. For more details, please refer to the Molina Electronic Data Interchange (EDI) Services, Inc. *Submitter Testing Report* for the DHH.

Testing Tier II

Once each SMO has successfully passed more than 50% of their encounter data claims through the pre-processors, Molina will process the encounters through the MMIS Adjudication cycle and the Payment cycle. The Payment cycle will create an 835 transaction to be retrieved by the SMO via IDEX. Each SMO is required to examine the returned 835s and compare them to the encounter data claims (837s) they submitted to ensure all claims that were submitted are accounted for in the data collection. Molina will send the new edit code reports to the SMO and DHH/Mercer for evaluation as well as a MMIS edit code explanation document which details the conditions under which each edit code will post to an encounter data claim in order to assist them with their research. Molina is available to answer any questions that any SMO may have concerning the edit codes.

Testing Tier III

Once satisfactory test results are documented, Molina will move the SMO into production. Molina anticipates receiving files from the SMO in production mode at least once monthly.

Appendix I

Websites

The following websites are provided as references for useful information not only for SMO entities, but also for consumers, health care providers, health care organizations, and other impacted entities.

Website Address	Website Contents
http://aspe.hhs.gov/admnsimp/	This links to the **Department of Health and Human Services website regarding the Administrative Simplification provisions of HIPAA**. This site contains downloadable versions of the proposed and final rules, general information about the administrative simplification portion of the HIPAA law, an explanation of the Notice of Proposed Rulemaking (NPRM) process, update on when HIPAA standards may be implemented, and presentations made by parties regarding HIPAA.
http://www.cms.gov	This is the **CMS home page**.
http://www.wedi.org/snip/	This is the **Workgroup for Electronic Data Interchange**

Website Address	Website Contents
	website. This site includes information on EDI in the health care industry, documents explaining the Privacy Rule, lists of conferences, and the availability of resources for standard transactions.
http://www.wpc-edi.com/hipaa/HIPAA_40.asp	This links to the **Washington Publishing Company website**. This site contains all the implementation guides, data conditions, and the data dictionary (except for retail pharmacy) for X12N standards being proposed under HIPAA of 1996. They may be downloaded for free.
http://www.ansi.org	This is the **American National Standards Institute website** that allows one to download ANSI documents. You may download a copy of ANSI Procedures for the Development and Coordination of American National Standards, or a copy of ANSI Appeals Process.
http://www.x12.org	This is the **Data Interchange Standards Association website**. This site contains information on ASC X12, information on X12N subcommittees, task groups, and workgroups, including their meeting minutes. This site will contain the test conditions and results of HIPAA transactions tested at the workgroup level.
http://www.nubc.org	This is the **National Uniform Billing Committee website**. This site contains NUBC meeting minutes, activities, materials, and deliberations.

Website Address	Website Contents
http://www.nucc.org	This is the **National Uniform Claims Committee website**. This site includes a data set identified by the NUCC for submitting non-institutional claims, encounters, and coordination of benefits. This site also includes information regarding purpose, membership, participants, and recommendations.
http://HL7.org	This site contains information on Logical Observation Identifier Names and Codes (LOINC) - **Health Level Seven (HL7)**. HL7 is being considered for requests for attachment information.
http://www.cms.hhs.gov/home/medicare.asp	This is the **Medicare EDI website**. At this site, you will find information regarding Medicare EDI, advantages to using Medicare EDI, Medicare EDI formats and instructions, news and events, frequently asked questions about Medicare EDI, and information regarding Medicare paper forms and instructions.
http://www.cms.hhs.gov/medicaid/hipaa/adminsim/hipaapls.asp	This is a **monthly newsletter published by CMS's Data and System Group within the Center for Medicaid and State Operations**. It is a very good source of information for HIPAA developments. If you cannot access the website with the direct address, use http://www.cms.gov. Click on Medicaid and search using the keywords "HIPAA Plus".